



Republic of Namibia

Plan for National Multisectoral Monitoring and Evaluation of HIV/AIDS



2006/7 - 2008/9



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Ministry of Health and Social Services

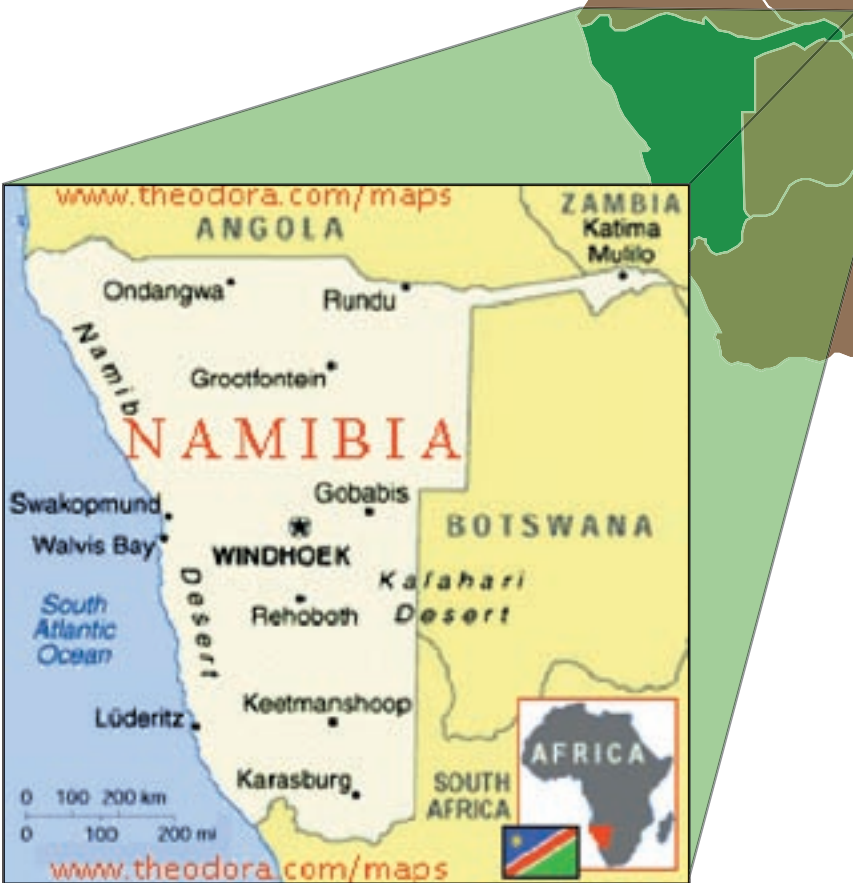
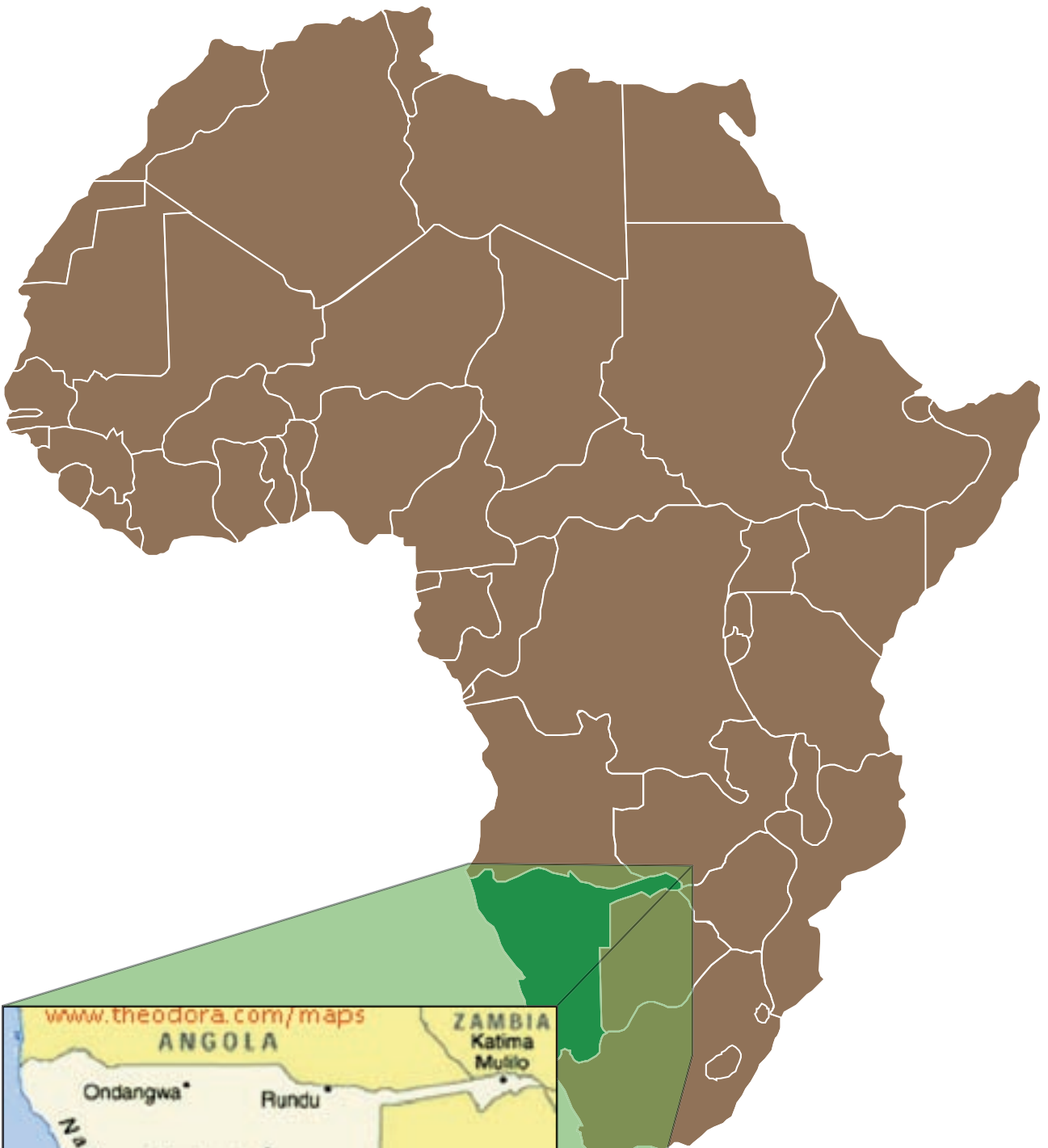
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Preface

In Namibia, the public sector, Lironga Eparu, civil society organizations, private sector and other initiatives have developed programmes to expand the responses to the national HIV/AIDS epidemic. The global momentum is to scale up the responses to HIV/AIDS pandemic so as to turn the tide of the epidemic, it has become increasingly important for countries to be able to report accurate, timely and comparable data to national authorities and , development partners; including , and in meeting commitments of the global community;, in support toof to strengthening the response programmes and accountability.

International targets and indicators are important in because they allow cross -national comparisons and global assessment of progress towards reaching the goals. National monitoring and evaluation allows programmes to monitor their progress in implementation and also provide feedback to the stakeholders at national, regional and community level to: 1) identify and address challenges; 2) refine and adapt implementation strategies; and; 3) asses the effectiveness, efficiency and impact of their interventions.

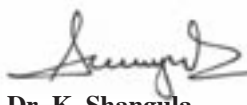
The purpose of this M&E plan is to guide the country response with essential information on the core indicators that measure the effectiveness of the national response to HIV/AIDS. It also provides a guide in determining the level of success of programmes in the provision of services, identifying areas where further support is required and guides adaptation and scaling up strategies. This plan presents a summary of the HIV/AIDS M&E system that is being developed and strengthened for the MTP III whereby all role players in the response have the opportunity to contribute to and to make recommendations.

This Monitoring and Evaluation plan has been a result of collaborations with many stakeholders in the country at all levels. This document intends to guide all those involved in the national response to HIV/AIDS towards the implementation of the global idea of the third “one”: of the “Three Ones”; that is, “a ONE agreed -upon one national multisectoral monitoring and evaluation system in the country”.

Establishing an M&E system is not an easy task; translating the system into action is even harder and more challenging. It is in this regard that all stakeholders are encouraged to give emphasis and support for the one national M&E system with subsidiaries, allocate enough resources for M&E activities and enhance the capacity of their own staff through training and experience sharing.

I would like to take this opportunity to acknowledge the work done by the following: the staff in the Directorate Special Programmes especially those in the Subdivision Response Monitoring and Evaluation, Office of the Under Secretary: Health Care Services & Social Welfare Policy in the MoHSS, all public sectors, NGO’s, FBO’s, Civil Society, private sector and development partners for their contribution towards development of this document and for their support to strengthen the M&E of HIV/AIDS in the country.

Let us work all together toward one common goal: one agreed upon national multisectoral monitoring and evaluation system for Namibia.



Dr. K. Shangula

Chairperson

Namibia Coordinating Committee for HIV/AIDS, TB & Malaria



List of Abbreviations

ABC	Abstinence, Behaviour change, Condoms
AIDS	Acquired Immuno Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ANC	Ante-natal clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour change communication
BCI	Behaviour change intervention
CACOC	Constituency AIDS Co-coordinating Committee
CRIS	Country Response Information System
CBS	Central Bureau of Statistics
CBO	Community based Organisation
CDC	Centre for Disease Control and Prevention
CMS	Central Medical Stores
DACOC	District AIDS Coordinating Committee
DHS	Demographic & Health Survey
DSP	Directorate: Special Programmes
DPP&HRD	Directorate: Policy, Planning and Human Resource Development
ETR	Electronic TB Register
EU	European Union
FBO	Faith-based Organisation
FHI	Family Health International
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
GRN	Government of the Republic of Namibia
GTZ	Gellschaft für Technishe Zusammenarbeit
HAART	Highly active anti-retroviral therapy
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
IEC	Information, education, communication
KAP	Knowledge, attitudes, practices
M&E	Monitoring and evaluation
MOE	Ministry of Education
MOHSS	Ministry of Health and Social Services

MOL	Ministry of Labour
MOU	Memorandum of Understanding
MTP III	Third Medium Term Plan on HIV/AIDS
MGECW	Ministry of Gender Equality and Child Welfare
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Committee
NaCCATuM	Namibia Coordinating Committee for HIV/AIDS, TB & Malaria
NACOBTA	Namibia Community-based Tourism Association
NACOP	National Aids Co-ordination Programme
NBTS	Namibian Blood Transfusion Service
NANASO	Namibia Network of AIDS Service Organisations
NASOMA	Namibia Social Marketing Association
NCPI	National Composite Policy Index
NGO	Non Governmental Organisation
NIP	Namibia Institute of Pathology
NPC	National Planning Commission
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
QPMR	Quarterly Programme Monitoring Report
RACOC	Regional AIDS Co-coordinating Committee
RM&E	Response Monitoring and Evaluation Subdivision
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

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CHAPTER 1: BACKGROUND

1.1 Country Profile at a Glance

The Government of Namibia has acknowledged that HIV/AIDS is a serious developmental problem and invests substantially into fighting against the disease. The HIV/AIDS epidemic increased and spread to all areas of the country during the decade of the 1990s, though regional, age, and rural-urban differences remain. The first AIDS case in Namibia was diagnosed in 1986.

Since 1990, there has been a resurgence of energy and commitment in the response to the epidemic in the country. Together with development partners, the Government of Namibia is making a difference curbing the spread of the HIV and restoring quality of life to people infected and affected.

Namibia has a generalized HIV/AIDS epidemic with HIV primarily transmitted through hetero sexual transmission. From a 1992 estimate of 4.2%, prevalence rose rapidly over the following 4 years to 15.4% in 1996. Prevalence continued to rise less rapidly for the following 6 years to a peak of 22.0% in 2002. National prevalence showed an apparent decline to 19.7% in 2004. The overall trend in HIV prevalence is illustrated in Figure 3. It is evident that the reduction in prevalence between 2002 and 2004 represents the first ever drop in prevalence since Namibia began bi-annual sentinel surveillance.

1.2 National Response

In Vision 2030, HIV/AIDS is addressed as a crosscutting issue in all sectors, and more specifically under the theme of Population, Health and Development. The strategies highlight the need for leadership at all levels, a multi-sectoral approach, the promotion of policies to combat stigma and discrimination, the inclusion of HIV/AIDS in all development plans, a greater understanding of the impact of HIV/AIDS on all the different sectors, and an enhanced ability to monitor impact. The Second National Development Plan (NDP II) complements the strategies and targets laid out in Vision 2030 and MTP III.

The MTP II was reviewed in February 2003 and the recommendations guided the MTP III development. The Mid Term Review of MTP II concluded that although much progress has been made and good ground work done, several areas of the national response needed strengthening. Areas identified for renewed attention were commitment, human resource capacity building, improved financing and enhanced coordination, cooperation and monitoring and evaluation.

The Third Medium-Term Plan on HIV/AIDS for the years 2004-2009 serves as a guide for sector response to the epidemic, as well as a management and coordination tool for all those involved in the fight against the epidemic. As the major determinants for HIV transmission lie outside the health sector, effective management and control of the HIV/AIDS epidemic call for a multi-sectoral approach.

The MTP III National Programme Goal is to reduce the incidence of HIV infection to below the epidemic threshold. It has been developed to assist planners, implementers, and monitoring and evaluation agencies to focus their efforts in expanding the response to the HIV/AIDS epidemic in Namibia and to reach the targets set under the following five key result areas also called components;

- Enabling Environment
- Prevention
- Treatment, care and support
- Impact mitigation and
- Programme Management

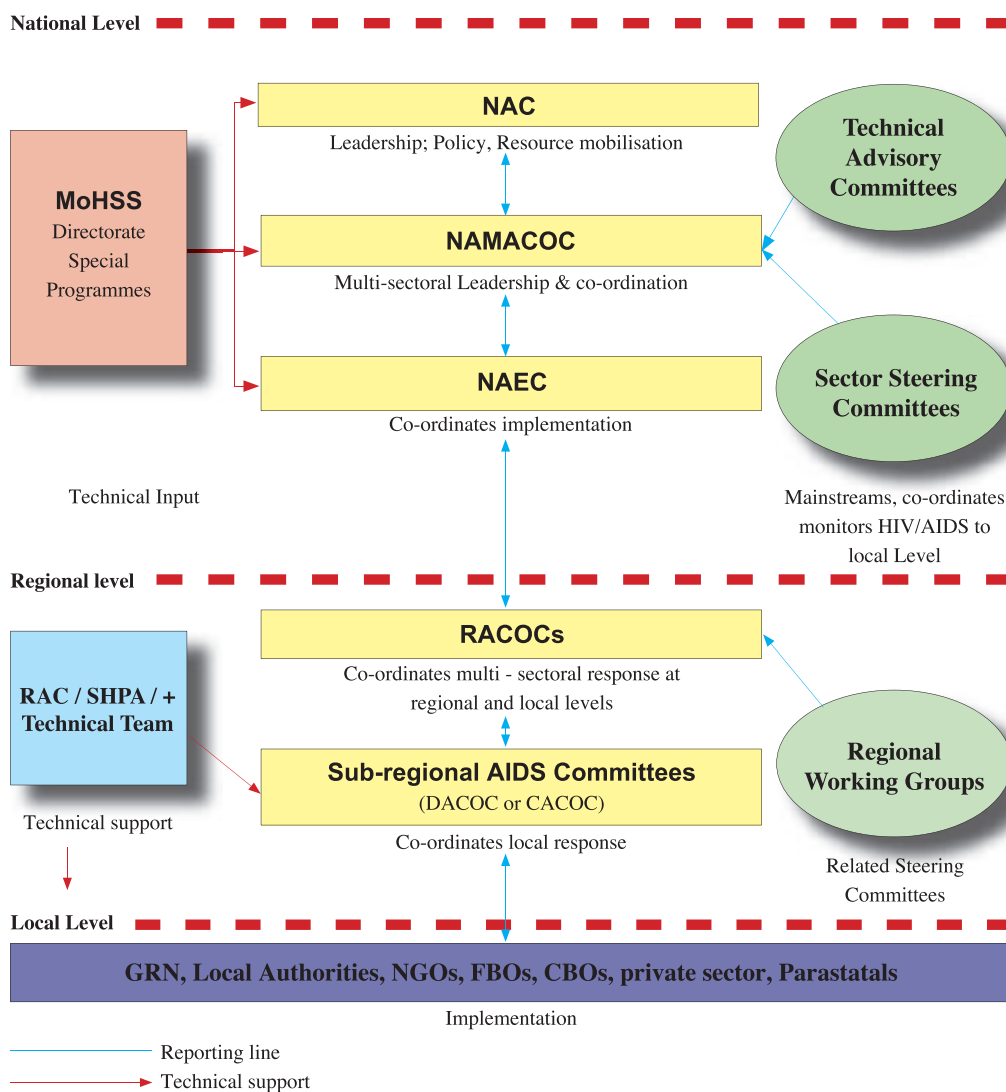
Financial resources for HIV/AIDS have increased considerably. The last three years alone financial resources doubled and concerted efforts are being made to extend prevention, care, treatment and support to infected and affected people in the regions and districts.

1.3 Structure of the National Response to HIV/AIDS

MTP III describes the roles and responsibilities of the various mechanisms and committees at the different organisational levels of the national response. These include the National AIDS Committee, chaired by the Minister for Health and Social Services, which reports directly to Cabinet, as well as Sectoral Coordination Committees and Regional AIDS Coordination Committees.

In 2002, Cabinet approved the new structure of the MoHSS which made a provision for a new Directorate to design, manage and direct policy development, strategic planning, resource mobilisation, co-ordination, facilitation, monitoring and evaluation of the national response across all sectors to reduce the impact of HIV/AIDS, TB and Malaria on the Namibian population. The Directorate has two divisions, one focusing on the health sector requirements and the other on the multi-sectoral response.

Figure 1: Organogram of the National AIDS Coordination Programme



The mandate of the DSP/NACOP is to coordinate the national response to the epidemic using the Medium Term Plan as its operating framework. This plan encourages the involvement of all sectors and assists to mobilize resources for the response.

1.4 MTP III and M&E

The MTP III builds on the process whereby the GRN through the National AIDS Committee (NAC) will monitor the overall effectiveness the strategies outlined in MTP III. It will monitor processes of resource mobilisation, allocation and utilisation in the public sector. It will further monitor the extent to which its decentralised management and administrative structures facilitate HIV/AIDS prevention and mitigation efforts and the integration of HIV/AIDS at national and regional council levels.

DSP/NACOP will collaborate with stakeholders and implementing partners to develop an overall M&E guideline. This guideline will define each data source for the national indicators and specify how and how often data will flow from local to the national levels, and how data will be compiled, analyzed and reported upon.

Following these above mentioned components, Chapter IV of the MTP III lists the goals and outcomes, indicators, targets, and responsible agencies

1.5 International and Regional Commitments

The Government of Namibia is signatory to a variety of international and regional declarations and commitments that form the background of the national HIV/AIDS monitoring and evaluation system. In addition to this, the international community has mobilised significant resources to scaling-up efforts in-country. Some of the key commitments carry with them indicators for national reporting, such as UNGASS, Millennium Development Goals, and WHO 3 by 5. These were merged with or integrated into the national list of indicators to ensure accurate and timely reporting to these particular commitments.

Therefore the basis of the M&E plan is the MTP III indicators listed under the five components and the integrated indicators related to UNGASS, MDG's and other commitments.

CHAPTER 2: INTRODUCTION

2.1 Monitoring and Evaluation Definitions and Concepts

Monitoring and Evaluation is a management tool that is built around a formal process for monitoring and evaluating performance using indicators that help respectively measure progress toward achieving intermediate targets or ultimate objectives and goals, and assess relevance, efficiency, effectiveness and impact. The purpose of monitoring and evaluation is to improve the HIV/AIDS programmes and the infrastructure for delivering them and to guide the allocation of resources in current and future programmes. Monitoring systems comprise procedural arrangements for data management (collection, collation, analysis) and reporting (see Fig 1. below). Evaluation is a process that consists of various components which are adapted to the circumstances.

Internationally, standards and guidelines have been developed for HIV/AIDS monitoring and evaluation systems. These have been documented in a series of M&E manuals. The National HIV/AIDS M&E System for Namibia complies with these standards and guidelines.

Monitoring is the continuous, routine, daily, and regular assessment of ongoing activities and/or processes. It aims to provide the management and main stakeholders of an ongoing intervention with early indications of progress (or lack thereof) towards the achievement of outputs.

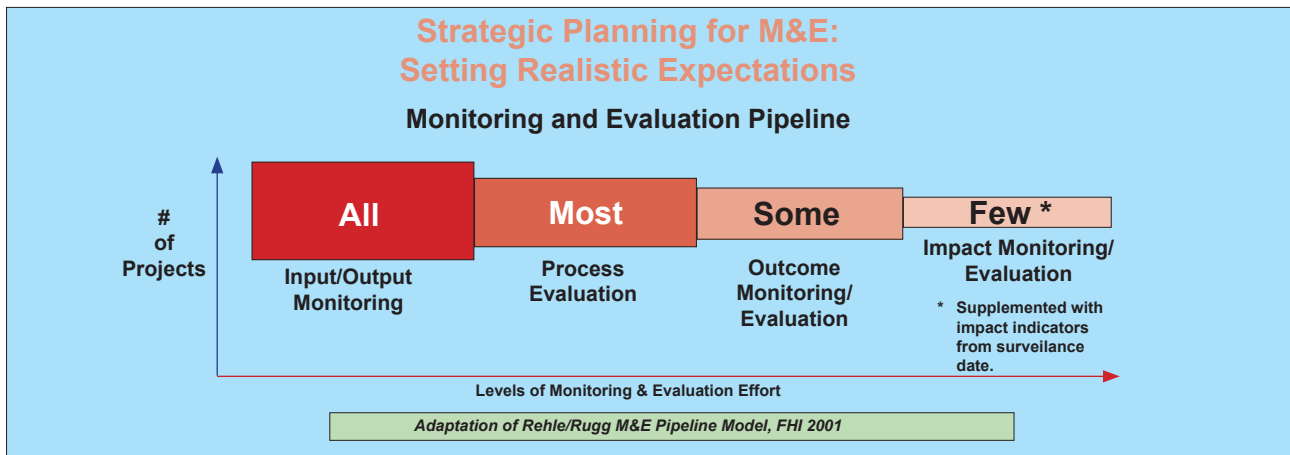
Evaluation is the episodic assessment, as systematic and impartial as possible, of the overall achievements of activities and/or processes. It aims to understand the progress that has been made towards the achievement of an outcome at a specific point in time. All evaluations are linked to outcomes (impact) as opposed to only immediate results (outputs).

An indicator is a statement that describes the level of performance achieved in relation to a set of aims and/or objectives. An indicator provides evidence that a certain condition exists or certain results have or have not been achieved.

There are four levels of indicators (inputs, outputs, outcomes and impacts), as described below:

- Inputs are the resources that are needed to implement the project and its activities. Inputs can be expressed in terms of the people, equipment, supplies, infrastructure, means of transport, and other resources needed. Inputs can also be expressed in terms of the budget that is needed for a specific project or activity.
- Outputs are the immediate results of the activities conducted. They are usually expressed in quantities, either in absolute numbers or as a proportion of a population. Outputs are generally expressed separately for each activity.
- Outcomes are the medium term results of one or several activities. Outcomes are what the immediate outputs of the activities are expected to lead to. Outcomes are therefore mostly expressed for a set of activities. They often require separate surveys to be measured.
- Impact refers to the highest level of results, to the long-term results expected of the project. Impact therefore generally refers to the overall goal or goals of a project.

Figure 2: Monitoring and Evaluation pipe or chimney



The most relevant national indicators of the MTP III are the impact indicators to which all development partners preferably should adhere and provide support. Because of the varied and high number of stakeholders and the need for different levels of M&E it is of importance that the efforts are coordinated, simplified and harmonized where possible.

2.2 The “Three Ones Principle”

In 2004, representatives of major donor organizations and developing countries adopted three principles as the overarching framework to better coordinate the scale-up of National AIDS Programmes and related to the HIV/AIDS epidemic. **The “Three Ones Principle” is:**

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

The idea is to create, implement and strengthen a single, unified and coherent M&E system at the country level. This system should ensure that 1) relevant, timely and accurate data are made available to programme leaders and managers at each level of the programme and health care system, 2) selected quality data can be reported to national programme leaders; and 3) the national programme is able to meet donor and international reporting requirements under unified global efforts to contain the HIV/AIDS pandemic.

This M&E plan tries to develop and strengthen a sustainable national M&E system with support of all development partners. There needs to be consensus on a set of core indicators and information management that take into account the national capacity and needs of Namibia.

2.3 Components of a National HIV/AIDS M&E System

International guidelines stipulate that good HIV/AIDS M&E Systems include a number of components:

Existence of an M&E unit;

Clear goals and objectives of the M&E system;

A core set of indicators and targets;

A clear plan for data collection, analysis and dissemination.

Namibia's M&E System for HIV/AIDS takes these requirements into account, and arranges them in an operational framework that is implementation-focused. **Thus, the National M&E plan highlights the following features of the National HIV/AIDS M&E system:**

- Response M&E Subdivision within MoHSS
- Coordination: key line ministries (public sectors), civil society, private sector, development partners and coordination mechanisms
- Indicators
- Data management (tools, collection, databases, analysis, and dissemination)

2.4 Development process of the plan

This plan has been developed through participatory methods. A review of various national and international documents in regard to priority program areas, suggested indicators, and monitoring and reporting mechanisms compared to MTPIII, i.e. the UNGASS Report, the MTPIII, the Gap Analysis and the Vision 2030, NDP II.

The initial plan was developed with a variety of technical staff available in the country, which form part of the national M&E committee. The plan was shared and finalized with the national M&E committee comprising members from all stakeholders that play a critical role in the monitoring and evaluation of HIV/AIDS activities in the country. There were Consultative meetings with relevant stakeholders to gain an understanding of the status of the implementation of HIV/AIDS programmes, consensus building and enhancing ownership and accountability at each stage of implementation.

CHAPTER 3: STRATEGIC ANALYSIS

3.1 International and Regional Commitments

The need to monitor the effectiveness of HIV/AIDS interventions and the use of resources thus becomes a national priority. However, a comprehensive expenditure monitoring system is not yet in place. Reporting on the international and regional commitments described above will put a considerable demand on Namibia's M&E system; in particular placing additional burden on the already taxed capacity at national, regional and constituency levels. A phased approach is suggested to a) build consensus on core and additional indicators, b) institutionalized data sources, and c) establish data flow and reporting mechanisms.

3.2 Country Profile Analysis

Namibia's unequal population distribution across vast geographical distances contributes to the lack of health care access in some areas, in particular those living in rural areas. Variation also exists in hospital staffing and numbers of beds within the thirteen regions, with the best ratios found in urban areas, although more than half of the population resides in rural areas (Selma el Obeid et al, (2001). Health in Namibia: Progress and Challenges. RAISON, Windhoek, Namibia.)

Namibia's most economically active proportion of the population has within it the age cohorts which experience the highest levels of HIV prevalence. Economic factors such as poverty, disparity in income distribution, migration, commercial sex work and trans-generational sex play a significant role in furthering the epidemic. Other contributing factors that are generally accepted as linked to the epidemic, while not substantiated by research, include certain cultural practices, cross-border issues, gender inequalities, stigma, discrimination, denial, and violence against women and children. To date, ad-hoc and independent studies have been conducted on some of the most at-risk groups; however these studies fall short of fully exploring the links between HIV transmission and these phenomena.

The continued spread of HIV is likely to have dire consequences for the economy and the population as it alters the demographic structure of the country. Overall, there is a need to link HIV/AIDS surveillance with health service delivery, health information systems and behavioural research. This integration will better assess the trends of the epidemic and its contributing factors and will guide resource allocation, programme planning and programme implementation. A flexible M&E system will respond to the need for new interventions such as specific surveys and a comprehensive data dissemination plan will ensure that information reaches the widest possible range of consumers.

3.3 National M&E System Capacity

Weak coordination, inadequate human resources, insufficient funding and technical capacity are the major constraints which restrict Namibia's development of a cohesive and effective national M&E system. Currently HIV/AIDS systems are being developed in parallel but not in conjunction with a national over-arching system. Coordination should be managed by a national Monitoring and Evaluation Committee; however this structure in its current form is weak, with the roles of stakeholders undefined. The overall strategic focus for M&E is lacking and not supported by a comprehensive situation analysis. Legislation needs to be evaluated and aligned with national goals to ensure that M&E of HIV/AIDS is incorporated where applicable. Institutional capability exists throughout the country, however, competing priorities and a shortage of personnel places additional burden to an already-taxed cadre of human resources, thus reducing institutional capacity.

3.3.1 RM&E Subdivision & the Health Sector

The Response Monitoring and Evaluation (RM&E) Subdivision in the MOHSS Directorate of Special Programmes has the mandate to coordinate the implementation of a national and multi-sectoral M&E system in collaboration with other sectors and development partners. Significant capacity lies within the ministry in other Directorates such as Primary Health Care and Policy, and Planning and Human Resource Development, in which are located the MIS, research, and epidemiology functions. However, directorates often operate in isolation of each other and communication is disjointed. Collaboration between these directorates must be formalised to strengthen internal integration of M&E activities. Parastatal health organisations such as the Namibia Institute of Pathology and the Namibia Blood Transfusion Services are included in this group that experiences similar problems and requires improved collaboration in the response to HIV/AIDS.

Overall, human resource constraints exist throughout the health sector at all levels and constitutes the greatest need in M&E development. Analytical capacity of programme managers and health information staff in particular (including MIS programme managers) require capacity building throughout the structure. Where capability is present often there are competing priorities which prevent staff from delivering on programme and comprehensive national analysis. A developed M&E mechanism is required that will detail information flows and reporting requirements.

3.3.2 Coordination

With external development partners contributing remarkably to the total funding in Namibia to support or implement HIV/AIDS projects and programmes, it becomes clear how competing reporting requirements stretches already overburdened staff, particularly at local levels. In lieu of an established national M&E system, partners develop new databases, subsystems and surveys that may not be sustainable by the country in the long run. Development partners must support and strengthen the development of one national M&E system and align all related activities with national goals. The national M&E plan must be implemented immediately, in order to avoid a donor, demand-driven M&E system.

Most of the government ministries are active in the national response in some way; however none have established HIV/AIDS M&E units but all have HIV/AIDS/M&E Focal persons on the staff establishment. This too is the same for the umbrella organisations for civil society, private sector and People Living with HIV/AIDS (PLWHA). Although they have not established any M&E units, public, civil society and private sector organisations has been addressing their M&E roles as per MTP III for the past years. The linkage between multi-sectoral monitoring of HIV/AIDS within individual sectors and the national M&E system is still lacking. Although MTP III explains sector mandates, guidance is still needed to establish M&E components, focal persons and mechanisms.

3.3.3 Indicators

Most HIV/AIDS programmes tend to stop at the development of programme-level indicators, and do not collect what is necessary to fulfil data needs for national response reporting. Institutionalisation of data sources will address this issue and enable sectors to take responsibility for data collection of national indicators and foster a sustainable M&E system. Programmes and sectors should, at a minimum, ensure that they collect those indicators that feed into the overall national indicator set.

3.3.4 Data Collection & Analysis

Many information systems currently in place throughout the government are often not aligned with government Information Communication Technology (ICT) policies. This contributes to disjointed information that lacks overall guidelines and can lead to wasted resources. Data quality also becomes jeopardised when systematic reviews and data validation are not being carried out. There are several related systems that house data which is important to the HIV/AIDS response (e.g., statistics on vital registration, information on national health accounts, OVC registration, etc). These systems need to be reviewed and harmonised with the overall HIV/AIDS M&E system, and should ideally follow government protocols and guidelines.

Data collection is also compromised in that the health system uses health districts for points of data collection while the Central Bureau for Statistics uses different enumeration areas. This confuses sampling methodologies and can lead to problems with comparability of samples in research and other studies undertaken, and when statistics from various sources are combined in one study.

A rapid assessment of existing data collection mechanisms in and outside the health sector should explore where key indicators may be incorporated into existing systems and to help identify the storage of information and reporting flow.

3.3.5 Data Dissemination

Use of information for programme planning and implementation is another area that is lacking in the country. While resources are devoted to data collection, often information is not synthesized to analyse the overall picture and reports that are written are not used in reviewing programmes and for future planning. A national HIV/AIDS Data Dissemination Plan should be implemented and stakeholders trained to guide the analysis and use of data.

Chapter 4: Strategic Direction

4.1 Rationale for a National Multisectoral HIV/AIDS M&E System

The need for a national HIV/AIDS M&E system is stipulated in Chapter 4 of the National Strategic Plan on HIV/AIDS. There is a need for such a system for the following reasons:

- To strengthen the multisectoral response and national commitment toward HIV/AIDS;
- Namibia is a signatory to many international commitments, including the UNGASS, and Maseru Declarations thus the need to monitor the effectiveness of HIV/AIDS interventions and the use of resources becomes a national priority;
- Donor organizations and developing countries adopted the “Three Ones Principle” as the overarching framework to better coordinate the scale-up of National AIDS Programmes. A well defined HIV/AIDS M&E system is the third one of these principles. Countries should work towards achieving the third “one”: one agreed upon M&E system at country level that will allow monitoring towards the progress made in the fight against HIV/AIDS;
- Namibia needs to continuously track its progress made towards the achievement of the National Multisectoral HIV/AIDS response as per the National Strategic Plan;
- The HIV/AIDS programmes in the country are supported by many national and international donors at different levels in the country. Effort should be made towards collaboration for a harmonised and aligned M&E system in the country.

4.2 Vision

To utilize effective, well-coordinated monitoring and evaluation in the guidance of the national response to HIV/AIDS that will lead to reduced HIV infections by the year 2009.

4.3 Mission

- To effectively lead and coordinate the M&E efforts of all stakeholders in the multi-sectoral national response to the HIV/AIDS epidemic by:
- Facilitating the implementation of the Third Medium Term Plan (MTPIII)
- Monitoring and evaluation of the multi-sectoral national response
- Communicating and advocating key issues of the national response to stakeholders

4.4 Core Values

- Quality service
- Visionary
- Strategic management
- Responsive
- Results-oriented
- Teamwork

4.5 M&E Plan objectives

The purpose of the M&E Plan is to establish an effective coordinated National Multisectoral Monitoring and Evaluation system for HIV/AIDS to:

- Ensure evidence based policies, plans and programmes;
- Systematically collect and use data to track progress and for informed decision making on the key interventions;
- Assess the impact by monitoring trends and explain changes in the levels of HIV/AIDS prevalence over time;
- Define a list of core indicators that will enable tracking of progress in the most critical areas of the fight against HIV/AIDS;
- Develop a data collection strategy that will enable the measurement of the core indicators;
- Establish clear data flow channels between the different stakeholders in the fight against HIV/AIDS;

- Develop a strategy and mechanisms to ensure a correct dissemination of all critical information amongst all stakeholders, implementing agencies, beneficiaries and the general public;
- Clearly describe the role of each of the stakeholders in the monitoring and evaluation of HIV/AIDS programmes;
- Develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of HIV/AIDS programmes.

Table 1: M&E Strategies

DSP/ MoHSS: RM&E Subdivision	<ul style="list-style-type: none"> • Coordinate HIV/AIDS, TB, Malaria surveillance and research, and programme monitoring and evaluation and provide the secretariat for the M&E coordination mechanisms; • Provide effective, timely and relevant information to decision makers and stakeholders on the progress and constraints of the national response to enhance informed decision making and mobilization and allocation of resources; • Establish an institutionalized network with key line ministries, civil society and private sector, and external development partners on HIV/AIDS multisectoral M&E towards one national M&E plan; • Provide technical guidance to strengthen M&E capacity among key stakeholders on systematic collection, processing and analysis of data at various levels and quality assurance, standardization of M&E methodologies and tools across multiple actors at various programme levels.
OPM, MRLGHRD, MGECW, NANASO, NABCOA, MOE	<ul style="list-style-type: none"> • Coordinate HIV/AIDS, TB, Malaria surveillance and research, and programme monitoring and evaluation in key line ministries, civil society and private sector; • Submit timely and relevant information to the RM&E subdivision; • Provide technical guidance to strengthen M&E capacity among key line ministries, civil society and private sector with support from the RM&E Subdivision.
Coordination	<ul style="list-style-type: none"> • Ensure a platform for partnership, networking and collaboration between national level and local level stakeholders in monitoring and evaluating various components of the MTPIII <ul style="list-style-type: none"> a) Support the development of a multi-sectoral M&E system, where the MoHSS in collaboration with other key line ministries actively coordinate, collect and analyze data in support of the Response M&E Subdivision in DSP/MOHSS through either mainstreaming HIV/AIDS indicators into existing M&E systems where possible and develop new M&E structures and mechanisms where needed. (This needs to be done through the established M&E coordination mechanisms); b) Ensure a strong partnership between international development partners and the Government of Namibia in support of a national M&E system development that is sustainable and in line with the needs of Namibia. The partnership is based on harmonization and alignment as agreed in the three ones principle and Paris declaration. (This through representation with in the M&E committee and participation in ad hoc M&E working groups and make resources available for capacity building for national M&E systems).
Indicators	<ul style="list-style-type: none"> • Build consensus on a core set of national indicators that focus on impact and outcomes of the national response. A programmatic-level M&E system collects data for use by the managers and usually collects more indicators than needed. Due to the high number of programmes there is a need to drastically rationalize the number of indicators.
Data management	<ul style="list-style-type: none"> • Identify existing data sources and collection channels and integrate HIV/AIDS and TB routine data collection; • Strengthen and where needed develop alternative mechanisms for data collection, especially in the multi-sectoral response; • Support to national agreed upon surveys that form an integral part of the data sources; • Support standardized tool development (multi-sectoral HIV/AIDS, resource projections and tracking etc.); • Assist in compiling and analyzing data within the RM&E Subdivision, and other M&E units through database development and capacity building of staff; • Reach consensus on quarterly reporting requirements and formats for data dissemination.

4.6 Critical Success Factors

- Successful implementation of the national Monitoring and Evaluation Plan
- Multi-sectoral M&E capacity building at all levels
- Roles, responsibilities and institutional linkages clarified and agreed-upon
- Development of teambuilding and coordination within the RM&E Subdivision and between the Subdivision and key development partners
- Timely availability of identified human resources and infrastructural requirements
- An established budget line for the RM&E Subdivision to support all activities in the work plan

Chapter 5: Strategic Implementation

The previous section explained that the national M&E plan concentrates on a national M&E framework for HIV/AIDS. This framework involves substantial coordination. It deals directly with some key stakeholders and more indirectly with many more agencies, including public sector, civil society, development partners and private sector.

The government and several development partners have committed increased resources for the operationalisation of the MTP III; and therefore it is imperative that agencies develop a coherent national M&E system, and avoid creating many parallel systems. As the national M&E framework still is being developed, it is important to adopt a phased approach towards an effective, efficient and sustainable system. The sections below provide a brief description of the situation followed by the main strategies.

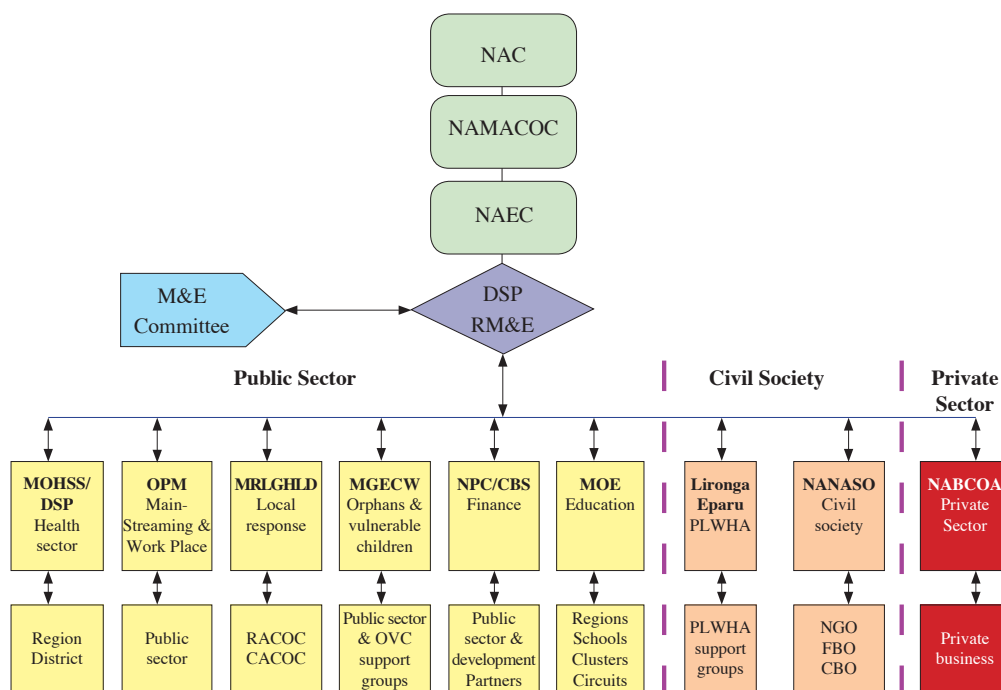
5.1 Coordination

The response monitoring and evaluation requires a greater coordinated involvement by all public sectors, parastatal, and the private sector, NGOs, faith-based organizations and development partners to optimize resources and maximize common experience sharing. A list of sectors/Stakeholders can be found in Annexure K. All sectors implementing HIV/AIDS activities should monitor their intervention programmes and report through a few selected key stakeholders to the DSP RM&E Subdivision. The Subdivision subsequently is responsible for compiling and analyzing the data for national and international reporting and dissemination to all sectors and stakeholders as per agreed Monitoring and Evaluation Subdivision and key stakeholders format and frequency.

A strong partnership between Government and international development partners is required in the support of a national M&E system development that is sustainable and in line with the needs of Namibia. The partnership is based on harmonization and alignment as agreed in the three ones principle and Paris declaration. The development of a multi-sectoral M&E system, where the MoHSS in collaboration with other key line ministries actively coordinate, collect and analyze data in support of the RM&E Subdivision in DSP/MOHSS through either mainstreaming HIV/AIDS indicators into existing M&E systems where possible and develop new M&E structures and mechanisms where needed.

The organogram below shows the lines of coordination/data collection/ reporting/ dissemination between the Response and the National HIV/AIDS coordinating structures.

Figure 3: Organisational structure for the response monitoring and evaluation of HIV/AIDS



The National AIDS Committee (NAC) is the highest policy decision-making body, under Cabinet, on matters related to HIV/AIDS. All M&E output reports will be submitted to this committee for endorsement.

The National Multi-sectoral AIDS Co-ordination Committee (NAMACOC) provides the leadership for multi-sectoral and regional implementation. This committee will review progress made by the multisectoral and regional structures and make recommendations to NAC.

The National AIDS Executive Committee (NAEC) will provide the technical leadership to the M&E committee.

The RM&E subdivision within the DSP is responsible for the coordination of all multisectoral monitoring and evaluation activities.

The National M&E Committee provides the leadership for multi-sectoral and regional implementation of all M&E activities related to HIV/AIDS (annex ToR). The committee roles are to ensure a platform for partnership, networking and collaboration between national level and local level stakeholders in monitoring and evaluating various components of the MTPIII. It consists of representation from all stakeholders in the national fight against HIV/AIDS.

Development partners are members of the national M&E Committee and many of the international organisations that are present in Namibia play an important role in the monitoring and evaluation of HIV/AIDS interventions.

The MoHSS Health Sector data is generated from health facilities and forwarded to districts and then regions before being submitted to the Epidemiology division at national level. Therefore most relevant indicators and information management need to be mainstreamed within existing M&E systems. It is also important that health surveillance, service delivery and health systems M&E becomes better institutionalized and linked to the national M&E system.

The OPM HIV/AIDS unit is responsible for coordination of work place programmes in the public sector, therefore the M&E thereof. The unit to date has no (fulltime) focal point for M&E and it is urgent that this is established and includes a budget for M&E.

The MRLGHRD has the mandate of serving as Government focal point for policy and operational matters at the regional (RACOC) and constituency (CACOC) levels. It ensures the efficient operation and coordination of the local authorities; social, welfare and community mobilization as well as the provision of basic physical and social infrastructure. The HIV/AIDS unit is currently being developed. There is a budget for staff and activities but the M&E component is yet not established.

The MGECW plays a leading role women and child welfare, more especially for orphans and vulnerable children (OVC) and households affected by HIV/AIDS.

The NPC/CBS is responsible for the coordination of mainstreaming of HIV/AIDS activities in the public sector. It also provides the framework for data collection and data management of national statistics in the country.

The MOE is responsible for the education sector, more especially for introduction of HIV/AIDS life skills programmes for children in school.

NANASO is the umbrella organisation for civil society organizations that play a crucial role in the response to the HIV/AIDS epidemic in Namibia. Civil society organisations implement several HIV/AIDS programmes at the national, regional, district and local levels. These organisations through NANASO therefore play an important role in the monitoring and evaluation of the national response through the activities they implement.

NABCOA is the umbrella organization for the private sector responsible for the workplace programme. The private sector provides a large part of the clinical care and it has the responsibility of the provision of adequate HIV prevention and care services for its workforce.

Lironga Eparu is the umbrella organization for support groups of People Living with HIV/AIDS (PLWHA) nationwide. They have the responsibility to coordinate and support local PLWHA support groups and also focus on psychosocial support, treatment support, and advocacy for PLWHA.

Currently, the three umbrella organizations described above which represent the largest proportion of the national response to HIV/AIDS do not have established M&E units. It is necessary to build the capacity of these umbrella organizations to include M&E focal persons supported by dedicated M&E budgets.

5.1.1. National Level

The Response Monitoring & Evaluation Subdivision in the Directorate for Special Programmes within the MoHSS is the coordinating unit for the national response monitoring and evaluation for HIV/AIDS (MTP III) and the secretariat to the National M&E Committee and subsequent sub-committees and working groups.

The Subdivision faces human resource challenges as it currently consists of 3 staff members (Chief Health Programmes, a Statistician and a data clerk). This is insufficient considering the mandate assigned to it and the high expectations from stakeholders. The subdivision receives technical assistance and other support; however still falls short of fully operationalisation of the M&E system. The subdivision needs additional human resources in the following functional areas to realize the strategies in Box 1 :

- Programme Monitoring and Evaluation
- Surveillance and Research coordination
- Secretariat for coordination and administrative support
- Information management

The RM&E Subdivision will convene regular M&E committee meetings to bring together key implementers of HIV/AIDS programmes and regions/districts to discuss issues relevant to the implementation of the national M&E plan. Partnership Forum meetings will also be used to update stakeholders on the requirements for the national M&E framework and to solicit their support for implementation.

5.1.2. Regional, District and Constituency and other Levels

The indicators included in the national M&E plan are primarily to measure progress made at national level, however regions/districts/constituencies can measure their progress once programmatic indicators has been disaggregated at their levels. These data will be useful for planning and decision making at each of these levels and the regions/districts and constituencies can have their own additional indicators based on their local needs.

The DSP staff from the MoHSS and staff MGLGHRD will be responsible for coordinating the regional response monitoring and evaluation for HIV/AIDS. These staff will be responsible for compiling and disseminating information to the RACOC, CACOC, DACOC and the DMT. RM&E Subdivision will provide support to the staff at regional, district and constituency levels.

To harmonize data collection for indicators required at national level and well as at local level, it is essential that regional/district/constituency committees hold regular meetings with all their partners.

5.2 National Multisectoral Monitoring and Evaluation

The implementation of the M&E plan involves/provides detailed indicator descriptions and describes the collection, flow, analysis, reporting, and dissemination of information, the organizations and individuals responsible for these tasks, and the data systems necessary to accommodate this information.

5.2.1. Organisation of the national indicators:

Conceptually, the framework of the M&E system is structured to include Impact, Outcome, Output, Process and Input Assessments. The national M&E system will monitor impact, outcome and some output while the programmatic monitoring will include some outcome, process and input monitoring. For purposes of the national M&E system, the outcome assessment is structured along the five strategic result areas of the Third Medium Plan on HIV/AIDS (MTPIII):

- Component 1: Enabling environment
- Component 2: Prevention
- Component 3: Access to treatment, care & support services
- Component 4: Impact mitigation services
- Component 5: Integrated & coordinated programme management at all levels

Table 2: Summary of national indicators

Impact Indicators			
Ref No	Indicators	Data source	Disaggregated by
1	HIV prevalence among pregnant women	National HIV sentinel survey report	By age group and sentinel site
2	Percentage of adults and children with HIV still alive at 6, 12 and 24 months after initiation of antiretroviral therapy	HIS (ARV)	By age group
3	Percentage of infants born to HIV infected mothers who are infected	PMTCT Programme estimate	By age group
Outcome, Output and Input Indicators			
Component 1: Enabling Environment			
Ref No	Indicators	Data source	Disaggregated by
4	The amount of national funds spent by the government, civil society, private sector and development partners on HIV/AIDS annually	Resource Tracking form/UNAIDS Matrix	By sector
5	Percentage of large enterprises /companies (including line ministries) that have HIV/AIDS workplace policies and programmes	Workplace survey (AWPS)NABCOA	By company/enterprise
6	Percentage of population expressing accepting attitudes towards PLWHAs	DHS/AIDS	By age group and region
Component 2: Prevention			
Ref No	Indicators	Data source	Disaggregated by
7	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and taught it during the last academic year	Annual Education Census (AEC)	By type of school
8	Percentage of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner	DHS/AIDS	By age group, urban/rural and region

9	Number and Percentage of health workers who receive post-exposure prophylaxis (PEP)	HIS (ARV), /HFS, URC	By region
10	Percentage of young people taught life-skills-based HIV/AIDS education in past 12 months	AEC/ UNICEF	By age group, out-of-school/in school and region
11	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	DHS/AIDS	By age group, urban/rural and region
12	Percentage of young women and men who have had sex before the age of 15	DHS/AIDS	By age group, urban/rural and region
13	Percentage of women and men who had sex with more than one partner in the last 12 month	DHS/AIDS	By age group, urban/rural and region
14	Percentage of employees in public/private sectors that have been reached by work place programmes in the past 12 months	Workplace survey NABCOA	By sector and region
15	Percentage of women and men who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	DHS/AIDS, OPM	By age group, urban/rural and region
16	Percentage of transfused blood units screened for HIV	NBTS	
17	Number of people completing the testing and counseling process (pretest, counseled tested, & Post-test counseled)	HIS (VCT), SMA	By age group and region
18	Number of new clients treated for sexually transmitted infection	HIS	By age group, region and type of STI
Component 3: Access to Treatment, Care and Support Services			
Ref. No.	Indicators	Data source	Disaggregated by
19	Number of health personnel/others trained to deliver ART/PMTCT /VCT/Rapid testing/TB/HBC services according to national/international standard	Training Information Management System (TIMS)	By region and type: ART, PMTCT, VCT, Rapid testing, TB, HBC
20	Percentage of health facilities with drugs for ARV/OIs in stock and no stock outs in last 6 months	Health facility survey/PMIS	By region/Facility and type of medicine: OI or ARV
21	Percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission	HIS (PMTCT), QPAMS	By age group and region
22	Percentage of TB patients tested for HIV	Electronic TB Register (ETR)	By age group and region
23	TB treatment success rate	Formula-based estimate	By age group and region
24	Percentage of women and men with advanced HIV infection receiving ART	HIS (ARV)	By age group and region
25	Number of vulnerable populations (sex workers, mobile population etc) who report always using a condom every time they had sex in the last month	Behavioural surveillance or DHS/AIDS	By region and type of vulnerable population
26	Number of vulnerable populations (sex workers, mobile populations ect) who have ever voluntarily requested an HIV test, received the test and received their result	Behavioural surveillance or DHS/AIDS	By region and type of vulnerable population

Component 4: Impact Mitigating Services			
Ref. No.	Indicators	Data source	Disaggregated by
27	Percentage of orphans and vulnerable children whose households receive free basic external support in caring for the child	DHS/AIDS	By age group, urban/rural and region
28	Ratio of current school attendance among orphans to that of non-orphans	DHS/AIDS, EMIS, Census	By age group and region
Component 5: Integrated and Co-ordinated Programme Management at all levels			
Ref. No.	Indicators	Data source	Disaggregated by
29	Percentage of national, regional and sectoral management structures with comprehensive HIV/AIDS plans which are financed annually	Regional profile of RACOC, CACOC, & DACOC	By management structure
30	Percentage of line ministries reaching 80% of criteria measuring mainstreaming (e.g. policy, annual plans, guidelines, budget, management committees with HIV/AIDS on agenda	Sector reports, Workplace Survey	By Ministry

The Government is signatory and therefore committed to report to the following international and regional declarations that are relevant for the monitoring and evaluation system for HIV/AIDS:

- Abuja Declaration and UNGASS Declaration of Commitment on HIV/AIDS
- Millennium Declaration
- 3 by 5 Initiative
- Maseru Declaration

All indicators for the abovementioned commitments will be integrated into the national M&E system /harmonised with the national indicators.

Strategies:

- Reach consensus on a core set of national indicators that focus on impact and outcomes of the national response;
- A programmatic-level M&E system collects data for use by the managers and usually collects more indicators than needed;
- Maintain modesty in the beginning on the number of indicators and allow more indicators to be collected following the capacity development.

5.3 Data management

5.3.1. Tools

During the development of the M&E tools, all key stakeholders will be involved. Under the “one M&E system’ all stakeholders will use tools of similar standards for routine data collection. Data will be managed at all relevant levels, compiled and synthesized by key stakeholders at the national level. The data will be presented to the M&E Committee before being published.

5.3.2. Data Sources of the National Indicators

The below table present data sources that are currently existing in all sectors. The M&E system will draw data from these listed sources. These data sources will formally be linked to the National system

In order to measure the indicators defined above, data sources for each of the indicators were indicated in the logical framework. The table overleaf provides key implementation-oriented information about each of the core data sources listed in the log frame.

Description of Data Sources

Key data sources for the national M&E system are described in detail below:

5.3.2.1. Quarterly Programme Monitoring Form

The Quarterly Programme Monitoring Form will be based on information filled out by public sector ministries/agencies, private sector and civil society organisations and development partners (i.e. all implementers of HIV/AIDS/STI/TB interventions), on a quarterly basis. See Annexure A, B and C for the forms.

An M&E guideline will be developed to inform stakeholders of how to complete this form, what data to collect in order to report effectively and how to report to DSP/NACOP. Stakeholders will then be trained in use of the guidelines and data collection tools and on-going support will be provided by the RM&E Subdivision to ensure smooth and timely reporting.

This form is the core of DSP/NACOP's programme monitoring process (collection of "programme implementation data") about the progress and extent of HIV/AIDS interventions. This will form the basis for the Quarterly Programme Monitoring Report that is outlined in Annex F.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	# of different radio and television programmes, and the total # of hours that these have been aired in this quarter	By type of media (radio/television)
2	# of different printed media produced, and the quantities of each that have been printed and distributed in this quarter	By region
3	# of communicators trained to strengthen coordination and capacity building on IEC at the local level	By disease category (e.g., HIV, TB, or Malaria)
4	# of municipalities with HIV/AIDS awareness services	
5	# of condoms distributed to end users	By type of condom (male or female), means (socially marketed or free), and region
6	% and # of clients trained in condom promotion	By region
7	% and # of learners exposed to life-skills-based HIV/AIDS education this quarter	By age, gender and region
8	% and # of teachers trained in LSE for HIV/AIDS in this quarter	By region
9	% and # of AIDS awareness clubs established	By region
10	% and # of health facilities offering PMTCT-Plus services	By region
11	% and # of pregnant women tested for HIV who are HIV positive	By age group (0 – 24, older than 24) and region
12	% and # of pregnant women receiving a complete course of antiretroviral prophylaxis	By age group (0 – 24, older than 24) and region
13	% and # of health workers trained for PMTCT services	By region
14	% and # of clients counselled and tested for HIV	By age (0 – 12, 12+ to 24, older than 24), region and sex
15	% and # of VCT supervisors trained	By region
16	% and # of VCT clients who tested HIV positive	By age (0 – 12, 12+ to 24, older than 24), region and sex
17	% and # of counsellors trained to provide VCT (i.e., professional or community counsellors)	By region
18	% and # of VCT centres established	By region

19	% and # of persons trained in home-based care and support for chronically ill persons (i.e., caregivers, members, volunteers)	By sex
20	% and # of chronically ill persons enrolled in community home-based care and support projects	By sex
21	% and Total # of home-based kits distributed	By region
22	% and Total # of home-based kits replenished	By region
23	% and # of PLWHA support groups established	By region
24	% and Total # of PLWHA provided with skills training (income generation, advocacy, national code for HIV/AIDS and employment, positive living, managing support groups)	By sex and region
25	% and # of persons receiving ARV therapy	By gender, age group & type of health facility
26	% and # of licensed doctors trained in comprehensive case management for ART	By region
27	% and # of health workers (excluding licensed doctors) trained to implement, monitor, and supervise comprehensive case management for ART	By region
28	% and # of caregivers and health workers who receive post-exposure prophylaxis (PEP)	By region
29	% and # of health facilities offering ART	By region
30	% and # of orphans and other vulnerable children receiving psychosocial, material or nutritional support	By type of support region & sex
31	% and # of persons trained in providing care and support to orphans and other vulnerable children (community volunteers/members/caregivers)	By region
32	% and # of municipalities	
33	% and # of municipalities with work place policies	
34	% and # of municipalities with HIV/AIDS focal points	
35	% and # of municipalities with HIV/AIDS committees	
36	% and # of municipal HIV/AIDS committees trained to design, manage and implement HIV/AIDS programmes	
37	% and Total # of workplaces that have been provided support to develop workplace policies according to national code on HIV/AIDS in employment	By region
38	% and # of workplaces that have established a condom procurement and distribution system	By region
39	% and # of workplace peer educators trained	By region
40	% and # of clients treated for sexually transmitted infections this quarter	By sex, age and region
41	% and # of Network members benefiting from training activities conducted by NANASO	By region
42	% and # of training workshops for NANASO network members conducted	
43	% and # of service providers trained to provide peer education	By region
44	% and # of people reached through peer education	By region
45	% and # of operational research studies and surveys conducted	By region and disease type (HIV/AIDS, TB and/or malaria)

Using information provided on Quarterly Programme Monitoring Form, DSP/NACOP will prepare a Quarterly progress Report with cumulative totals for the respective quarters and will submit this to NAC and all stakeholders within a month of the end of the quarter for their information and use in decision-making.

Once a year, NAC and all stakeholders will receive an annual report from the DSP/NACOP, with cumulative totals of all the above required information.

5.3.2.2. Demographic and Health Survey

The DHS is a robust instrument for tracking changes in knowledge and behaviour at a national level. This survey is conducted every 5 years in the country. The core DHS questionnaire emphasizes basic indicators and flexibility. It allows

for the addition of special modules, such as the DHS HIV/AIDS Module, so that questionnaires can be tailored to meet specific country data needs. The standard DHS survey consists of a household, women's and a men's questionnaire. A nationally representative sample of people ages 15-49 are interviewed.

The DHS AIDS module will supplement the regular DHS on a biennial basis.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Percentage of population expressing accepting attitudes towards PLWHAs (National Indicator No. 6: Target 75% by 2007; 100 % by 2009 – MTP III P. 87)	By gender, residence and level of education
2	Percentage of people knowing where to go for legal assistance or counseling regarding stigma and discrimination (Target 30% by 2007; 80 % by 2009 – MTP III P. 87)	By age group and sex
3	Percentage of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner (National Indicator Target: Listed by age groups p.88 MTP III)	By gender, residence and age
4	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (National Indicator No. 11: Target 95% by 2007; 99% by 2009)	By gender & residence
5	Percentage of young women and men who have had sex before the age of 15 (National Indicator No. 12: Target 75% by 2007; 100 % by 2009 – MTP III P. 87)	By gender & residence
6	Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months. (National Indicator No. 11: Target 75% by 2007; 100 % by 2009 – MTP III P. 87)	By gender & residence
7	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner. (National Indicator No. 15: Target : listed by sex and age group – MTP III P. 88)	By gender & residence
8	Median age at first sex among 15-24 year-olds. (Target 17.5 by 2007; 19 by 2009 – MTP III P. 89)	By gender & residence
9	Percentage of women and men aged 15-24 who have never had sex. (MTP III P. 89)	By age group & residence
10	Percentage of young people exposed to IEC services	By age group, gender & residence
11	Percentage of sexually active respondents who had sex with a non-regular partner within the previous 12 months. (National Indicator No. 13)	By age group, gender & residence
12	Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 month. (National Indicator No. 13)	By age group& residence
13	Percentage of 15-49 year age group that have correct knowledge of the principal services and key therapies available for treatment, care and support. (Target 40% by 2007; 60% by 2009 – MTP III P. 89)	By age group, gender & residence
14	Percentage of orphans and vulnerable children whose households receive free basic external support in caring for the child. (National Indicator No. 27: Target : listed by sex and age group – MTP III P. 93)	By age group, gender & residence
15	Ratio of current school attendance among orphans to that of non-orphans. (National Indicator No. 27: Target : listed by sex and age group – MTP III P. 93)	By age group, gender & residence

As per the Strategic Plan of the Directorate Policy, Planning and Human Resource Development, the DHS is done every 5 years. The next DHS will take place in 2006, and then 2010 thereafter.

5.3.2.3. *Electronic TB Register*

The Electronic TB Register is a user-friendly, Epi-Info based software programme based on the WHO/IUATLD format of recording and reporting. Individual records from the TB registry are entered in a programme that provides interactive support. The software provides several patient management and supervision functions, such as lists of defaulters. Finally, it generates standard quarterly and annual reports on case-finding, sputum conversion, and cohort analysis, and provides graphs of trends and maps of TB indicators. The ‘Electronic TB Register’ software has been successfully implemented in Namibia. Factors critical for success of the ETR include a functioning, paper-based system; involvement of staff from the TB programme; health information systems; health facilities; ongoing training; and backup support.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Percentage of TB patients tested for HIV.(National Indicator No. 22: Target 50 % by 2007; 90 % by 2009 – MTP III P. 92)	By age group, gender & residence
2	% of TB patients HIV positive. (National Indicator No. 22: MTP III P. 92)	By age group, gender & residence
3	TB treatment success rate. (National Indicator No. 23: Target 75 % by 2007; 85 % by 2009 – MTP III P. 92)	By age group, gender & residence
4	% of TB patients on ART. (National Indicator No. 24: MTP III P. 92)	By age group, gender & residence

5.3.2.4. *Health Facility Survey*

Due to the need to understand the health services provided at health facilities as part of the HIV/AIDS response, specific information about services at health facilities is needed. This can be collated through two sources – a Health Information System or a specific health facility survey. Currently, the HIS does not provide adequate information about HIV-related services at health facilities. Due to this, this Operations Plan suggests a health facility survey be conducted through which the required information can be collected. Should the HIS be updated to include the periodic collection of some of this information (the preferred option) this data source could be amended.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Percentage of health care facilities that apply national standards for infection prevention. (Target 80 % by 2007; 100 % by 2009 – MTP III P. 88)	By type, district/region
2	Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counseled. (National Indicator No. 18: Target 75% by 2007; 95% by 2009 – MTP III P. 90)	By age group, gender & residence
3	Percentage of service delivery points providing counseling and testing using national quality standards. (National Indicator No. 17: Target 13 by 2007; 45 by 2009 – MTP III P. 90)	By type, district/region
4	Percentage of health facilities that apply national guidelines for blood storage, distribution, & transfusions. (National Indicator No. 16: Target 100 % by 2007; 100 % by 2009 – MTP III P. 90)	By type, district/region
5	Percentage of health facilities that meet national guidelines for monitoring and supervising ART.	By type, district/region
6	Percentage of health facilities with drugs for OIs in stock and no stock outs of >1 week in last 12 months. (National Indicator No. 20: Target 98 % by 2007; 100 % by 2009 – MTP III P. 92)	By type, district/region

7	Percentage of health facilities where ARV services are being offered with no ARV drug stock outs of >1 week in last 12 months. (National Indicator No. 20: Target 98 % by 2007; 100 % by 2009 – MTP III P. 92)	By type, district/region
8	Number and Percentage of health facilities that meet national guidelines for the provision of PMTCT services. (National Indicator No. 21:– MTP III P. 92)	By type, district/region
9	Percentage of health facilities that provide treatment for opportunistic infections according to guidelines. (National Indicator No. 18: Target 70% by 2007; 90% by 2009 – MTP III P. 92)	By type, district/region

The health facility survey would need to be undertaken every three years in order to provide relevant information for the national HIV/AIDS M&E system. The report should be available in January in time for inclusion in HIV/AIDS M&E report.

5.3.2.5. Health Information System (HIS)

The HIS is a public health planning and information system. It tracks a number of national health indicators at all health facilities in Namibia. HIS data is collected by each health facility in the country on a monthly basis. This data is then sent through the district to the region and then national HIS unit where it is aggregated. **The PMTCT ART, VCT and PCR systems are currently run as parallel systems, which are not yet fully integrated into the overall HIS. Plans are underway to integrate these systems into the overall HIS.**

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Percentage of adults and children with HIV still alive 12 months (6, 12 and 24 months) after initiation of antiretroviral therapy. (National Indicator No. 2:)	By age group, gender & residence
2	Percentage of infants born to HIV infected mothers who are infected. (National Indicator No.3)	By age group, gender & residence
3	Percentage of health workers who receive post-exposure prophylaxis (PEP). (National Indicator No. 9)	By age group, gender & residence
4	Number of new clients treated for sexually transmitted infections. (National Indicator No. 18:)	By age group, gender & residence
5	Number and Percentage of people completing the testing and counseling process (pre-test counseled, tested, post-test counseled). (National Indicator No. 17)	By age group, gender & residence
6	Percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission. (National Indicator No. 21)	By age group, gender & residence
7	Number and Percentage of health facilities offering PMTCT-Plus services. (National Indicator No. 21)	By district/region
8	Percentage of TB patients on ART. (National Indicator No. 22)	By age group, gender & residence
9	Number of health facilities [service delivery points] offering ART and comprehensive care including prevention services (By type and district). (– MTP III P. 90)	By age group, gender & residence
10	Percentage of districts with at least one centre that provides ART services in line with national standards 3. (– MTP III P. 90)	By age group, gender & residence
11	Percentage of women and men with advanced HIV infection receiving ART 2 3 (By age and sex). (– MTP III P. 90)	By age group, gender & residence
12	Number of male and female condoms distributed free to the general public. (– MTP III P. 90)	By age group, gender & residence
13	Percentage of health facilities where ARV services are being offered with no ARV drug stock outs of >1 week in last 12 months (By district). (– MTP III P. 92)	By age group, gender & residence

5.3.2.6. Annual Education Census

The UNGASS guidelines for all its indicators specify that a school-based survey should be carried out to determine the number of schools where life-skills-based HIV/AIDS education is taking place as well as where teachers have received training in life-skills-based HIV/AIDS education in Namibia.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Number of and Percentage of learners taught life-skills-based HIV/AIDS education in past 12 months. (National Indicator No. 10: Target xx by 2007; xx by 2009 – MTP III P. 88)	Type of school and sex
2	Number and Percentage of schools with teachers who have been trained in life-skills-based. (National Indicator No. 10: Target 50% by 2007; 75% by 2009 – MTP III P. 88)	By type of school & region
3	# and % of orphans exempted from school fees in the last academic year. (National Indicator No. 27,28: Target 30% increase by 2007; 80% increase by 2009 – MTP III P. 93)	By type of school (primary/secondary)

5.3.2.7. National HIV Sentinel Surveillance Report

Biological surveillance of HIV has been primarily tracked through surveillance of sentinel populations. Namibia began sentinel surveillance for HIV among pregnant women in 1992 and this is done biannually. Responsibilities for data compilation and analysis lie with the DSP within the MoHSS.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	HIV prevalence among pregnant women (National Indicator No. 1: Target : listed in – MTP III P. 86)	By age group, sentinel site & Urban/rural

5.3.2.8. Workplace Survey

To track the extent to which policy development efforts are mainstreamed in workplaces, UNGASS has developed an indicator on workplace policies and programmes. The data is derived from a workplace survey which should be conducted every 2 years. Private sector employers are selected on the basis of the size of the labour force. Public sector employers recommended are the ministries of transport, labour, tourism, education, and health. Employers are asked to state whether they are currently implementing personnel policies and procedures that cover, as a minimum, all of the following aspects:

- Prevention of stigmatisation and discrimination on the basis of HIV infection status in staff recruitment and promotion and employment, sickness, and termination benefits.
- Workplace-based HIV/AIDS prevention, control, and care programmes that cover: (a) the basic facts on HIV/AIDS, specific work-related HIV transmission hazards and safeguards, condom promotion, VCT, STI diagnosis and treatment, and provision of HVI/AIDS-related drugs.

Copies of written personnel policies and regulations should be obtained and assessed wherever possible. Indicator scores are required for all employers combined and for the private and public sectors separately. Estimates of the size of the male and female formal sector workforce should also be provided, based on latest available census data.

This survey will be undertaken in 2006 for the first time, and will then be done on an annual basis thereafter.

What does DSP/NACOP need from this data source

NO	INDICATOR	DISAGREGATION
1	Percentage of large enterprises/companies (including line ministries) that have HIV/AIDS workplace policies and programmes (National Indicator No. 5: Target 80% by 2007 , 90% by 2009 – MTP III P. 89)	By type
2	Percentage of employees in public/private sectors that have been reached by workplace programmes programmes (National Indicator No. 5: Target xx by 2007 , xx by 2009 – MTP III P. 89)	By Type

Table 3: Summary of Data Sources for National Multisectoral M&E System

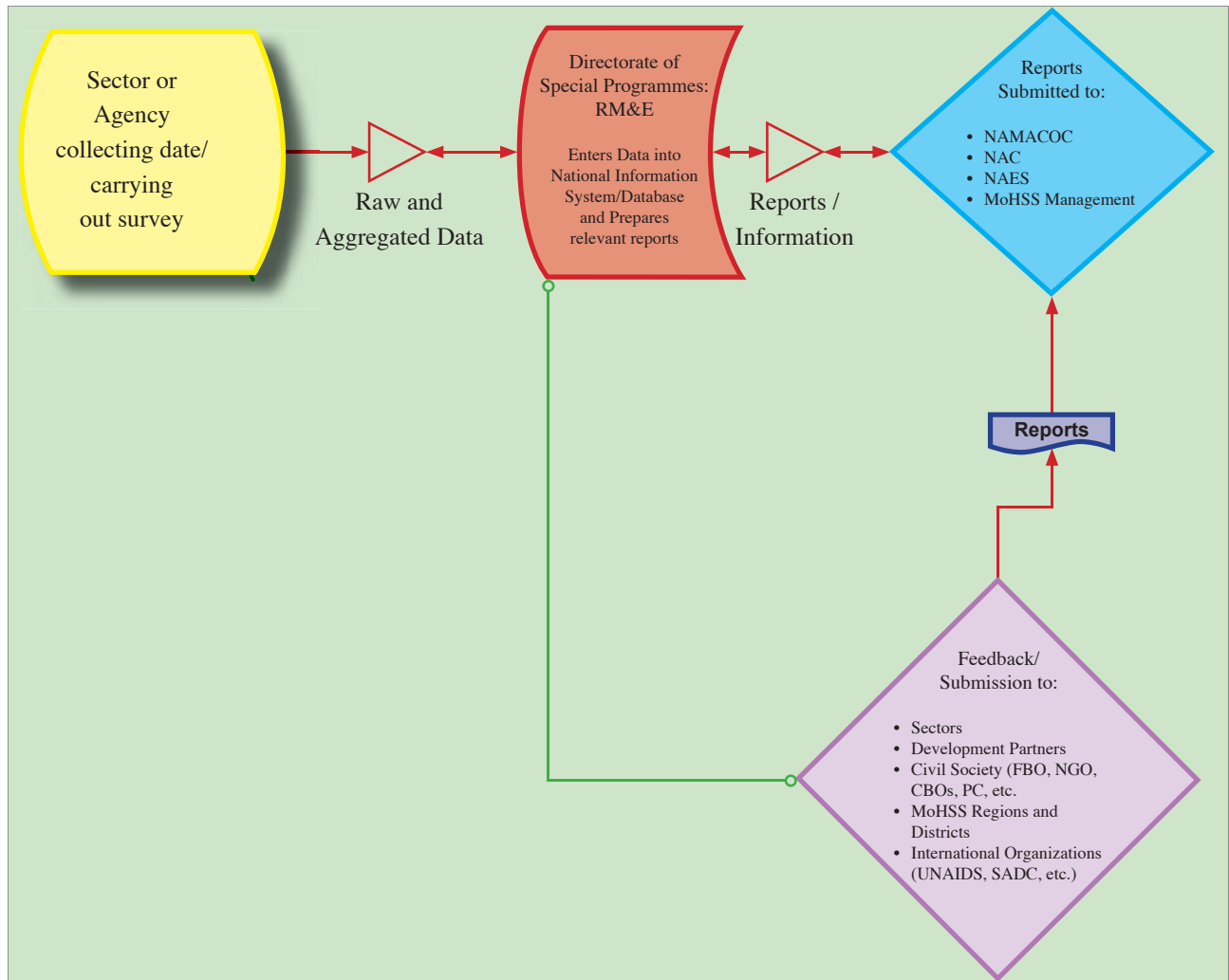
	DATA SOURCE	TIME PERIOD COVERED IN DATA SOURCE	FREQUENCY OF DATA COLLECTION	INSTITUTIONAL RESPONSIBILITY
1	Quarterly Programme Monitoring Forms	Quarterly	Quarterly submission to RM&E subdivision	Public, private and civil Society organisation
2	NDHS	Survey data collection period	Biennial	MOHSS/DSP & HRD
3	ETR	Jan - December	Annual	DSP/NACOP
4	Health facility survey (SAM/ SPA)	Survey data collection period	Biennial	MOHSS: DSP
5	Annual Resource Tracking Report	Annual	Annual	As above
6	AIDS Impact Survey (DHS HIV/AIDS Module, BSS)	Survey data collection period	Every 4-5 years	MoHSS/CBS
7	Sentinel surveillance	Time period that survey was undertaken	Biennial	MOHSS: Directorate Special Programmes
8	HIS (PMTCT/ ARV/VCT/ Morbidity/Mortality/etc)	Jan – December	Monthly/Quarterly	MOHSS: NHTC HIS unit
9	Annual Education Census (AEC)/EMIS	Jan - December	Annual	Ministry of Basic Education, Sports and Culture
10	NBTS	Quarterly	Quarterly	NBTS
11	Workplace survey	Survey data collection period	Annual	NABCOA

Strategies:

- Identify existing data sources and collection channels and integrate HIV/AIDS and TB routine data collection;
- Strengthen and where needed develop alternative mechanisms for data collection, especially in the multi-sectoral field;
- Support to national agreed upon surveys that form an integral part of the data sources;
- To support tool development (multi-sectoral HIV/AIDS, resource projections and tracking etc.);
- Assist in compiling and analyzing data within the RM&E Subdivision, and other M&E units through database development and capacity building of staff;
- Reach consensus on quarterly reporting requirements and formats for data dissemination

5.3.3 Summary of Data flow

Figure 4: Summary of Data Flow (include for public, private, civil society)



5.3.4 Data analysis

Analysis of data and report generation will involve all data producers and users. The M&E committee will be responsible for data analysis and report writing at national level led by the secretariat.

5.4 Information System Development

The OPM has been mandated by the Government to coordinate and oversee all ICT projects in all public sectors, therefore are the lead agency in database development and policy framework for the government. Guidance on the systems to be used will therefore be provided by OPM.

Various government ministries/agencies, NGOs, CBOs, civil society, research institutions and private companies collect data regarding the pandemic in diverse fields. This information is currently fragmented across the various domains and platforms, meaning that at any one time, planning, decision and policy making by any institution or stakeholder is done

with only a fraction of the information available. Currently there are also a number of uncoordinated different stand alone information systems that support the collection, collation, management and analysis of HIV/AIDS and health care data.

Coordinated information gathering and updating can be one of the most effective tools in fighting the pandemic. One therefore needs to develop a system that can make this possible on a national level, across all the various domains dealing with HIV/AIDS.

The Directorate of Special Programmes (HIV/AIDS, TB & Malaria) is in need to urgently set up a coordinated Information Communication System to effectively monitor and evaluate the implementation of the national HIV/AIDS policy and the Medium Term Plan III 2004 to 2009.

The purpose of the National M&E Database will be to capture data on HIV/AIDS that is periodically submitted to the DSP/NACOP in order to analyse and produce data and information products. It will also provide an inventory of HIV research, stakeholders and research organisations that are involved in HIV/AIDS.

Further, the HIV database needs to be developed in such a way that it can link to a website application, as the NACOP intends for some of the HIV database information to be available on the web. It also plans to use spatial analysis in future, so where possible data should be geo-referenced to allow for easy export to a Geographic Information System package.

5.4.1. Country Response Information System (CRIS)

CRIS is an information system for the national response to HIV/AIDS. The Response M&E Subdivision has currently installed the CRIS for reporting purpose to UNGASS. Although the system only consists of international indicators, the subdivision will explore the use of CRIS at regional, district, and constituency and by other stakeholders.

5.5 Information Products

In December 2003 and March 2004, the DSP/NACOP M&E team ascertained the information needs of its stakeholders through a series of visits and interviews and based on the requirements of DSP/NACOP and Namibia's obligations to international treaties. *Based on these information needs, the DSP/NACOP HIV/AIDS M&E system will produce the following periodic information products:*

- Quarterly Programme Monitoring Report
- Annual HIV/AIDS M&E Report
- Biennial UNGASS Report
- DSP Quarterly Bulletin
- Other research/survey reports

In addition to these periodic information products, DSP/NACOP would also respond to specific and ad hoc information needs of its stakeholders. Each of the periodic information products, and the process for accessing ad hoc information, has been described below.

5.5.1 Quarterly Programme Monitoring Report

DSP/NACOP will produce a Quarterly Programme Monitoring Report. This report will provide information on coverage statistics per HIV programme area, and will be based on the information provided by all stakeholders in the Quarterly Programme Monitoring Format. The production of this report will also ensure that DSP/NACOP meets requirements in terms of minimum reporting standards, as well as reporting to its other basket donors.

The purpose of this report is to provide a quick overview of service coverage in the last quarter to better inform implementers and development partners of the status of interventions of where gaps are and how to maximise resource utilisation. The main and only data source for this report is the Quarterly Programme Monitoring Report Form.

Once DSP/NACOP has collected and captured the data on a monthly/quarterly basis, it will compile a Quarterly Programme Monitoring Report, using a standard analysis methodology (descriptive statistics). This statistical analysis will be prepared for the approval process and dissemination to stakeholders. The DSP/NACOP RM&E Subdivision will disseminate directly to stakeholders (all organisations that submitted data). The format of this report will be based on the framework taken from the Third Medium Term Plan on HIV/AIDS in Namibia (MTP III). A format has been included in Annexure F of this Plan.

This report will be compiled on a quarterly basis, within one month of the end of the quarter. The report will be approved by the Director of the Directorate for Special Programmes, The Under Secretary: Health & Social Welfare Policy, and the Permanent Secretary of the MoHSS.

5.5.2 Annual HIV/AIDS M&E Report

The purpose of this report is to provide a comprehensive overview of Namibia's response to HIV/AIDS. This will be done by reporting on all indicators contained in DSP/NACOP's national HIV/AIDS M&E plan, and by providing key observations and guidance for future implementation. This report will be procedurally linked to the government's annual work planning and budgeting process to ensure that one does not pay lip service to the term "using information for decision-making".

The data sources for this report are all 11 core data sources mentioned in section 5.3 and Table 3 of this document. Should new and improved data sources become available, DSP/NACOP may also wish to supplement this list with additional data sources.

It should be noted that all indicators should be reported on using "the last 12 months" as a time frame set up. All data should focus on the last fiscal year (April - March), and this will be the de facto reporting period for the report. This will allow sufficient time for the report information to be used to guide work planning and budget for the following financial year (1 April to 31 March, as per Government of Namibia fiscal year).

The format of this report will be based on the information needs of DSP/NACOP and its stakeholders. Annexure G contains a pro forma layout of the report. DSP/NACOP will maintain this standard format to enable trend analyses. This report will be compiled on an annual basis by DSP/NACOP. The RM&E Subdivision will be responsible for drafting this report, with key support from the Director of Special Programmes. The report will be compiled during April/May of each year, and will be ready by 1 June every year. This will be in time for the HIV/AIDS M&E Report Dissemination Seminar in July/Aug of the same year.

The report will be approved by the Director of the Directorate for Special Programmes, the Under Secretary: Health & Social Welfare Policy and the Permanent Secretary of the MoHSS. This annual HIV/AIDS M&E Report will be disseminated to the stakeholders at the annual HIV/AIDS M&E Dissemination Seminar for MTP 3, to be held in July/Aug every year. All stakeholders from the public sector, private sector and civil society will be invited to attend. In addition to the national Dissemination Seminar for M&E results, there might be a need to organise regional dissemination seminars as well to ensure distribution to regional level.

5.5.3 Biennial UNGASS Report

Namibia is a signatory to the 2001 Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). Part of this Declaration of Commitment includes a set of indicators that the Government of Namibia has agreed to report on to UNAIDS on a periodic basis. All 17 UNGASS indicators have been included in the Namibia

HIV/AIDS National indicators. This will ensure that the data collection and analysis for the UNGASS indicators form part of the M&E processes within DSP/NACOP, and that it is not treated as a report “outside the scope of DSP/NACOP’s M&E mandate”.

The purpose of this report is to report to the UNAIDS on a periodic basis in terms of Namibia’s progress in the fight against AIDS, by reporting on 17 specific indicators in a manner defined in the UNAIDS Guidelines for the Construction of Core Indicators.

The data sources for the 17 UNGASS indicators is as per the data sources specific in the UNAIDS Guidelines for the Construction of Core Indicators, and can be summarised as follows:

- NCPI questionnaire
- AEC survey
- Workplace survey
- Health facility survey
- PMTCT and ARV programme monitoring and estimates (HIS)
- Demographic and Health Survey/HIV/AIDS Module
- HIV sentinel surveillance report

Data analysis will be carried out as per the UNAIDS Guidelines for the Construction of Core Indicators, and the datasheets for each of the 17 indicators will be completed, disaggregated as per requirements.

This report will be based on the format provided by UNAIDS, and will consist of a statistical overview of the data for each indicator, as well as a narrative description to add quality and texture to the statistical overview.

This report will be compiled on a biennial basis and is the responsibility of DSP/NACOP, RM&E Subdivision, with technical support from the in-country UNAIDS office. The report will be approved by the Director: Directorate for Special Programmes, The Under Secretary: Health & Social Welfare Policy, and the Permanent Secretary of the MoHSS.

5.5.4 Regular Information System Updates

All M&E reports produced by DSP/NACOP (Annual HIV/AIDS M&E report, Quarterly Programme Monitoring Report and the UNGASS report) will be available on DSP/NACOP’s website for electronic download (in PDF or MS Word format). This will ensure that DSP/NACOP stakeholders will be able to access up-to-date information. All HIV indicator data will be updated as and when new data becomes available in the DSP/NACOP database.

5.5.5 Ad Hoc Information Needs

In addition to the information products listed above, some stakeholders might have specific information needs at some stage. Although DSP/NACOP encourages the use of existing information products, it will assist if there are any specific and ad hoc information needs that are not covered in one of the above information products.

Such a request should be made in writing to the DSP/NACOP, and will then be considered. If possible, the request will be accommodated within the budget limitations of the RM&E subdivision within the Directorate for Special Programmes. If it is not possible, the person/institution will be informed of the cost implications.

Whether or not there are costs implications for DSP/NACOP to provide the ad hoc information need, DSP/NACOP will respond in writing to the request for ad hoc information within 5 working days of receiving such a request.

5.5.6 Quarterly Bulletin

DSP/NACOP will develop a quarterly bulletin summarises all relevant information on HIV/AIDS, TB and Malaria. The bulletin is targeted at all audiences including those who are not in the health profession, therefore will be written in a manner that is easily understood. The bulletin will form part of the documents that are disseminated every quarter. To ensure that the bulletin's content is widely understood, it will be translated into the local languages before dissemination. The development of the bulletin will be done by the Liaison Officers of the Directorate in collaboration with RM&E Subdivision.

5.6 Information Dissemination and Utilisation

In terms of implementation, this M&E Plan is linked to the annual work planning and budgeting process of the government which commences in July/Aug every year. This can only be practically achieved if the M&E Information Products are available prior to the work plan being developed, and will ensure that M&E results are used to inform decision making.

Various information products will be disseminated using a combination of various methods:

- Annual Regional Meeting;
- Annual Regional Support Visits;
- Emailing the reports;
- Annual M&E Dissemination Workshop;
- Sectoral Feedback Workshop/Meetings;
- Use of other feedback mechanisms already in place (e.g. regional meeting, sector meetings);
- Dissemination through media;
- MoHSS Website;
- DSP/NACOP/Documentation Centre, MoHSS Documentation Centre and Regional Resource Centre.

All information/reports produced will be disseminated to all relevant stakeholders including the private and public sector and civil society organizations. The reports/data will help programme Officers planning for the programmes.

5.7 Implementation of the national M&E system

5.7.1 Role of the National HIV/AIDS M&E Plan in Mid and End Term Evaluation

In terms of implementation, this M&E Plan is linked to (a) mid-term review of the National HIV/AIDS strategic plan in 2007, and (b) the annual work planning and budgeting process of the GRN which commences in July/Aug every year. This can only be practically achieved if the M&E Information Products are available prior to the work plan being developed, and will ensure that M&E results are used to inform decision making.

5.7.2 Implementation Cycle for the National M&E Plan (2006-2009)

In line with DSP/NACOP's overall mandate to coordinate the national HIV/AIDS response, proper coordination is needed to ensure implementation of the National HIV/AIDS M&E system. *The activities within the M&E work plan for the next 3 years can be categorised as follows:*

- Set-up of National HIV/AIDS M&E System
- Development of new data sources;
- Institutionalisation of all data sources;
- Agreement and preparation of budgets for new data sources;
- Agreement on customisation of existing data sources;
- Advocacy and senior briefing (Ministerial level, Permanent Secretaries and Regional Governors);
- Piloting of DSP/NACOP Programme Monitoring Report System;
- Training of and support to HIV implementers in the Quarterly Programme Monitoring Reporting Format;
- Agreement with donors about reporting to DSP/NACOP Programme Monitoring Report System.

Implementation of National M&E plan

- Generation of data sources not commissioned by DSP/NACOP;
- Generation of data sources commissioned by DSP/NACOP;
- Co-ordination to ensure that all data source information is received to inform all DSP/NACOP indicators;
- Development and dissemination of DSP/NACOP information products;

Database development

- Develop central database of HIV, TB, and Malaria data;
- Facilitate participation at national, regional, district and constituency level

5.7.3. Review of the National HIV/AIDS M&E Plan

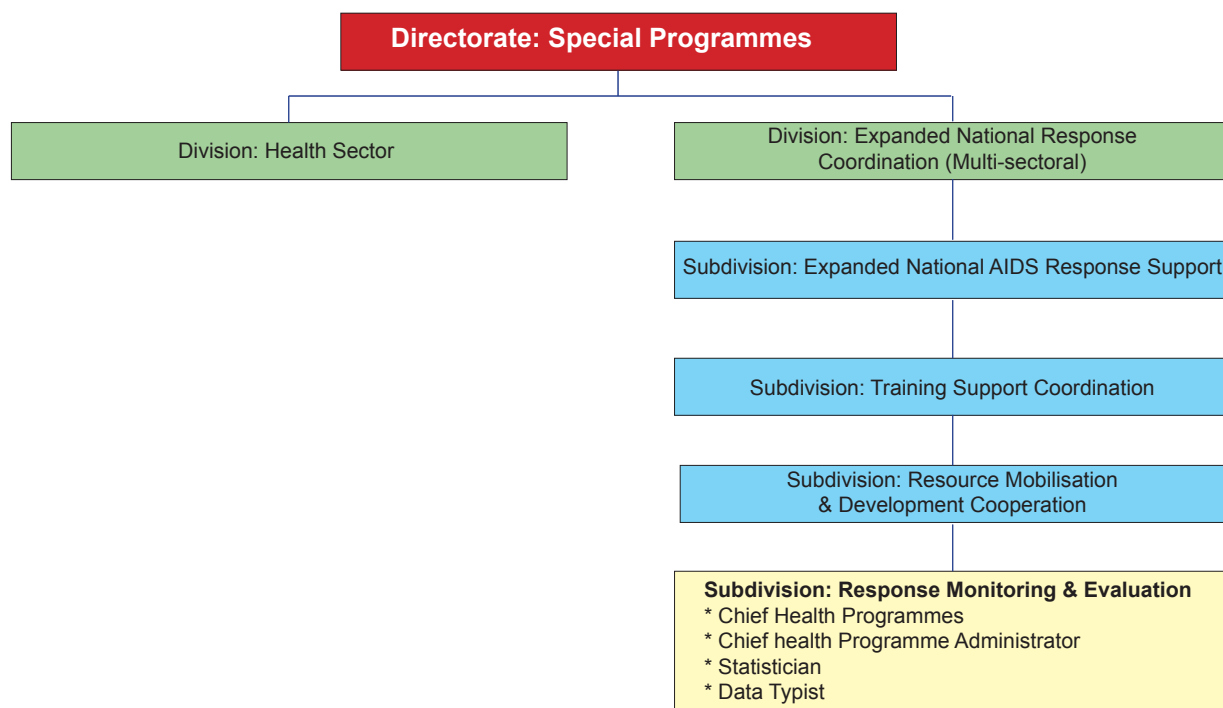
It has been acknowledged that due to the changing nature of the epidemic in Namibia and due to new research and technologies, HIV/AIDS is a dynamic area. This implies that reviews of this M&E plan to track the national HIV/AIDS response may be required from time to time. However, this need for revision of the plan should be balanced with the need to maintain a solid core set of data to enable trend analyses over time.

5.8 Role of stakeholders

5.8.1. The RM&E Subdivision

It is in the mandate of RM&E to coordinate the monitoring and evaluation of all HIV/AIDS interventions in the country. As such, RM&E plays a leading role in developing the National M&E Framework and in ensuring proper data collection, management and dissemination. RM&E will compile all the data that have been collected by its partners, analyse and disseminate the critical. RM&E will assist partners/stakeholders with the development of appropriate M&E strategies, systems and tools, and with capacity building where needed.

Figure 5: Staff establishment of the RM&E Subdivision in the DSP



5.8.2. The National M&E Committee

The committee is multisectoral and includes representatives from governmental departments, non-governmental organisations, the private sector, donor agencies, UN agencies, academic institutions and coordinating bodies, such as the Co-coordinating Assembly of Non-Governmental Organisations and the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL).

The National M&E Committee has been created whose task it is to assist in the coordination of all HIV/AIDS M&E activities in the country. It consists of M&E specialists from relevant government ministries, research institutions, donor agencies and NGOs, and representatives from all national HIV/AIDS coordinating bodies. The committee is chaired by one of its members on a rotation basis and will need to meet regularly. This committee plays a leading role in assisting M&E with the development of national M&E strategies, systems and tools, with developing M&E capacity amongst partners, and disseminating critical results. Many of the M&E Committee members will also be members of the sub-committees coordinating the different types of national surveys.

5.8.3. MRLGHRD

Regional and constituency coordinating structures for HIV/AIDS has been created in the MRLGHRD. Each of the regional/constituency offices will be required to coordinate the monitoring of activities conducted in their region/constituency. Each regional office has a regional HIV/AIDS Coordinator. Organisations implementing HIV/AIDS activities on a regional or constituency level, will report to the RACOC/CACOC, which will channel the information to the national level.

5.8.4. MoHSS

The MoHSS houses the National AIDS Coordination Programme (NACOP) that coordinates the national response to the HIV epidemic. The MoHSS also coordinates all HIV/AIDS programmes that are health facility related (condom distribution, VCT, PMTCT, STI care, blood safety, PEP, clinical care and CHBC) and houses the national managers of each of these programmes. The MoHSS is therefore responsible to coordinate the monitoring and evaluation of these programmes. An HIV/AIDS M&E Officer for the health sector (still to be established), based at the RM&E subdivision, will be responsible for the coordination across programmes.

The MoHSS plays also a critical role in providing information on disease surveillance as currently conducted by the health information system (HIS). The HIS is recently under revision to integrate the health facility based HIV/AIDS activities.

5.8.5. Other Public Sector Ministries/Agencies

Currently, no ministries other than the MoHSS are playing a major role in the national monitoring and evaluation of HIV/AIDS activities. *However, in the multi-sectoral approach the following ministries will need to play a larger role in the future:*

- The Ministry of Regional Local Government Housing and Rural Development currently coordinates the public sector response on HIV/AIDS and therefore will play a leading role in the M&E of these programmes;
- The Office of the Prime Minister coordinates all HIV/AIDS workplace programmes in the public sector and will therefore play a leading role in the M&E of these programmes;
- The National Planning Commission: Central Bureau of Statistics is responsible for the coordination of development partners and funds allocated for programmes in the country;
- The Ministry of Education (MOE) will play a major role in the monitoring and evaluating all school-based programmes;
- The Ministry of Gender Equality and Child Welfare plays a leading role women and child welfare, more especially for OVC and households affected by HIV/AIDS.

5.8.6. Civil Society Organisations

The civil society organisations play a crucial role in the response to the HIV/AIDS epidemic in Namibia. They are not only important programme implementers, but also play a role in the coordination of several HIV/AIDS programmes at the national, regional, district and local level. These organisations will therefore play an important role in the monitoring and evaluation of the national response through a correct monitoring and evaluation of the activities they implement, through their participation in the M&E committee, by providing technical assistance in some areas and by conducting part of the necessary surveys. Activities undertaken by civil society organisations in Namibia are coordinated by the umbrella organisation NANASO that represents the civil society organisations in the national M&E Committee.

5.8.7. The Private Sector

The private sector is another important player in the national response against the epidemic. It provides a large part of the clinical care and it has the responsibility of the provision of adequate HIV prevention and care services for its workforce. The role of the private sector in the national M&E framework lies mainly in the correct monitoring and reporting of their activities, but can also include assistance in the development of monitoring systems for specific programme areas, such as clinical care. Activities undertaken by private sector organisations in Namibia are coordinated by the umbrella organisation NABCOA that represents the private sector organisations in the national M&E Committee.

5.8.8. Development Partners and UN Agencies

Many of the international agencies that are present in Namibia play an important role in the monitoring and evaluation of HIV/AIDS interventions. They comprise, among others, UNAIDS that has a mandate to coordinate all HIV/AIDS activities supported by the UN agencies and those that are direct partners of MoHSS. Currently all development partners are members of the Partnership Forum except the USG partners. The development partners all play a major role in monitoring and evaluation, more especially providing financial and technical support in the implementation of the M&E activities. All development partners and UN agencies are all individually represented on the national M&E Committee.

5.9 M&E Costing

A costing exercise was conducted by a small working group comprised of the RM&E Subdivision and some stakeholders to determine the anticipated budgetary requirements of the 5 year M&E work plan. Each activity was calculated using nationally agreed-upon, standardized rates as used for other purposes (i.e., Global Fund proposal development costing) and includes a 5% annual increase to compensate for annual inflationary and depreciation adjustments.

Table 4: Costing for the National M&E system

MONITORING & EVALUATION SUMMARY OF ESTIMATED COSTS ACCORDING TO OBJECTIVE						
Activity		Cost per annum (N\$)				Total
		Year 1	Year 2	Year 3	Year 4	
		2006-7	2007-8	2008-9	2009-10	
Objective 1: To establish a national M&E response system and build M&E capacity						
1.1	Human resources					
	9 Sector clusters	1,890,000	1,984,500	2,083,725	2,187,911	8,146,136
1.1.1	(combined)					
1.2	Equipment					
	9 Sector clusters	339,498	356,473	374,297	393,011	1,463,279
1.2.1	(combined)					
1.3	Training & capacity building					
	DSP RM&E	605,000	635,250	667,013	700,363	2,607,626
	9 Sector clusters	450,000	472,500	496,125	520,931	1,939,556
1.3.2	(combined)					

Objective 2: To finalise and implement the national M&E strategy						
2.1	Dissemination	97,000	101,850	106,943	112,290	418,082
2.2	M&E Training Course	105,000	110,250	115,763	121,551	452,563
2.3	M&E requirements added to national guidelines	20,000	21,000	22,050	23,153	86,203
	Stakeholder training in M&E reporting requirements	48,300	50,715	53,251	55,913	208,179
Objective 3: To operationalise a national M&E database						
3.1	Database design & training	175,000	183,750	192,938	202,584	754,272
3.2	Equipment	100,000	105,000	110,250	115,763	431,013
Objective 4: To support, develop and implement data sources						
4.1	Annual Education Census	80,000	84,000	88,200	92,610	344,810
4.2	HIV Sentinel Surveillance Survey	1,200,000	0	1,320,000	0	2,520,000
	MOHSS Health information System	500,000	525,000	551,250	578,813	2,155,063
4.3	Financial and Programme Monitoring system	285,000	299,250	314,213	329,923	1,228,386
	Namibia Demographic and Health Survey	600,000	0	0	0	600,000
4.4	Workplace Survey	400,000	420,000	441,000	463,050	1,724,050
4.5	Health Facility Survey	700,000	735,000	771,750	810,338	3,017,088
4.6	Behavioural Surveillance (DHS HIV/AIDS Module, BSS)	4,800,000	5,040,000	5,292,000	5,556,600	20,688,600
Objective 5: To develop and implement a national HIV/AIDS research agenda						
5.1	Health sector	260,000	273,000	286,650	300,983	1,120,633
5.2	Multi-sector support	75,000	78,750	82,688	86,822	323,259
Objective 6: To develop data outputs and disseminate to stakeholders						
6.1	Annual HIV/AIDS M&E Report	80,000	84,000	88,200	92,610	344,810
6.2	Quarterly Programme Monitoring Report	80,000	84,000	88,200	92,610	344,810
6.3	Biennial UNGASS Report	0	50,000	0	55,000	105,000
6.4	Mid-term Review of Third Medium Term Plan (MTPIII)	0	1,500,000	0	0	1,500,000
	Mid-term Review of National M&E Plan	0	162,500	0	0	162,500
6.5	Final Review of Third Medium Term Plan (MTPIII)	0	0	0	1,725,000	1,725,000
	Final Review of National M&E Plan	0	0	0	186,875	186,875
6.6	National Secretariat functions	20,000	21,000	22,050	23,153	86,203
Total		12,909,798	13,377,788	13,568,552	14,827,855	54,683,993

The RM&E Subdivision will use the national HIV/AIDS M&E work plan to guide its activities and improve coordination of HIV/AIDS M&E amongst stakeholders in Namibia. The resources required to operationalise the M&E work plan are shown in the above table.

5.10 Technical support for M&E

Although M&E for the DSP/NACOP will be managed internally by the RM&E Subdivision, technical support may be required from time to time. Technical support in M&E may be provided through government funds, or externally by other development partners. Technical support required or offered should be in line with the national M&E workplan and combined with a local counterpart so that mentorship and capacity building takes place.

5.11 Capacity building

To date, no assessment of the M&E capacity for HIV/AIDS response management has been conducted in the country. However there is a need for development of the capacity at RM&E subdivision to coordinate the M&E of all HIV/AIDS activities at a national and regional level, the development of M&E capacity among national and regional programme coordinators, both at MoHSS and among other partners that play a role in the national coordination and the development of M&E capacity among implementing partners such as NGO, CBO, FBO, private institutions, etc.

Capacity building should include (1) training of programme management staff in M&E, (2) technical assistance for the development of M&E strategies, systems and tools, (3) financial support for M&E, and (4) practical focus to M&E – how to develop data registers, how to use basic software, and all the other aspects. However there is a need for development of the capacity at RM&E subdivision to coordinate the M&E of all HIV/AIDS activities at a national and regional level, the development of M&E capacity among national and regional programme coordinators, both at MoHSS and among other partners that play a role in the national coordination and the development of M&E capacity among implementing partners such as NGO, CBO, FBO, private institutions, etc.

References

1. Namibia Vision 2030
2. Second National Development Plan (NDP2) 2001/2002 – 2005/2006
3. National Strategic Plan on HIV/AIDS 2004 - 2009
4. UNAIDS National AIDS Programmes: A Guide to Monitoring and Evaluation (UNAIDS 2000)
5. Monitoring the Declaration of Commitment on HIV/AIDS:
6. Guidelines on Construction of Core Indicators (UNAIDS 2002);
7. National AIDS Councils: Monitoring and Evaluation Operations Manual (UNAIDS/World Bank 2002).
8. UNAIDS/The World Bank, 2002. National AIDS Councils. Monitoring and Evaluation Operations Manual.
9. UNAIDS (u.d). Monitoring and Evaluation Modules.
10. UNAIDS 2002. United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators.
11. UNAIDS 2000. National AIDS Programmes. A Guide to Monitoring and Evaluation.
12. Global Fund to Fight AIDS, Tuberculosis and Malaria, 2004. Monitoring and Evaluation Toolkit.
13. Ministry of Health and Social Services, National Guidelines for Voluntary Testing and Counseling.
14. Ministry of Health and Social Services. National Community Home Based Care Guidelines.
15. Ministry of Health and Social Services. National Guidelines for the Prevention of Mother to Child Transmission.
16. Zanzibar National Multisectoral Monitoring and Evaluation System: Guidelines for Zanzibar's HIV/AIDS Programme Monitoring System
17. Zanzibar National Multisectoral Monitoring and Evaluation System: Operational Framework 2005/6-2008/9 Volume 1
18. Swaziland National Multisectoral Monitoring and Evaluation System: Guidelines for Swaziland's HIV/AIDS Programme Monitoring System
19. Swaziland National Multisectoral Monitoring and Evaluation System: Operational Framework 2005/6-2008/9 Volume 1

Annexure A: Monthly Report Format for the Health Sector

1. Report Identification Details

Name of Directorate:		
Division:		
Subdivision:		
Postal Address:		
Name of M&E Focal Person:		
Report Compiled by:		
For more information / questions about the report, contact:	Name:	
	Tel number:	Fax:
	Email:	
Month/Year reporting on:		

2. Activities

COMPONENT 2: PREVENTION						
a) Condom distribution		Male condoms		Female condoms		TOTAL
ABC2	Number of condoms distributed free to the general public					
ABC3	Number of persons trained in condom promotion					
b) Information, Education and Communication (IEC) materials		RADIO		TV		PRINTED
		Number	Hours aired	Number	Hours aired	Number printed Number distributed
IEC1	Number of new HIV/AIDS radio/ TV programmes produced and aired					
IEC2	Number HIV/AIDS brochures/ booklets/news letters/posters printed and distributed					
						TOTAL
IEC3	Number of communicators trained to strengthen coordination and capacity building on IEC at the local level					
COMPONENT 3: EQUAL ACCESS TO TREATMENT, CARE AND SUPPORT SERVICES						
c) Prevention of Mother to Child Transmission (PMTCT)						TOTAL
PMT1	Number of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission					
PMT2	Number of health workers trained for PMTCT services					
PMT3	Number of health facilities providing PMTCT+ services					
PMT4	Number of HIV+ pregnant women					
PMT5	Number of HIV+ babies born to HIV+ women who received nevirapine					
d) Voluntary counseling and testing				Male	Female	TOTAL
VCT1	Number of clients completing the testing and counseling process					
VCT2	Number of service delivery points offering VCT services					
VCT3	Number of VCT centres established					
VCT4	Number of rapid testing delivery points established this month					

e) TB		Male	Female	TOTAL			
TB1	Number of TB patients tested for HIV						
TB2	Number and % of TB patients tested HIV positive						
TB- New HIV and leprosy cases		Male	Female	TOTAL			
TB3	Number of new TB cases that are HIV positive						
TB4	Number of new leprosy cases						
TB-New cases and relapses		New		Relapse		TOTAL	
		Male	Female	Male	Female	Male	Female
TB5	Number of smear positives						
TB6	Number of smear negatives						
TB7	Number of extra-pulmonary cases						
		Below 15 years		Above 15 years		TOTAL	
TB8	Number of PTB cases for below and above 15 years old						
f) Home based care and support							
CAR1	Number of persons trained to provide home-based care and support for chronically ill persons (i.e., CBO/village committee members, caregivers, community members, volunteers, pastors, family members etc)						
CAR2	Number of chronically ill persons receiving home based care (or enrolled in HBC and support projects)						
CAR3	Total Number of new home based kits distributed						
CAR4	Total number of home based care kits replenished						
g) Antiretroviral treatment		Male	Female	TOTAL			
ART1	Number of persons currently on ARV						
ART2	Number people starting ARV for the first time this month						
ART3	Number of PLWHA who adhere to ARV therapy						
ART4	Estimated number of people needing ART in the country						
ART5	Number of health facilities offering comprehensive ART services						
ART6	Number of licensed doctors trained in comprehensive case management for ART						
ART7	Number of health workers (excluding licensed doctors) trained to implement, monitor and supervise comprehensive case management for ART						
ART8	Number of people trained to provide support to family members on ART (includes HBC caregivers, family members, counseling staff)						
ART9	Number of caregivers and health workers who received post-exposure prophylaxis (PEP)						
ART10	Number of TB patients on ARV						
		6 months	12 months	24 months			
ART 11	Number of adults and children with HIV still alive at 6, 12 and 24 months after initiation of antiretroviral therapy						
h) PCR		Male	Female	TOTAL			
PCR1	Number and percentage of HIV-infected infants born to HIV infected mothers						
PCR2	Number of HIV exposed infants whose status is confirmed diagnosed by 12 months of age						

i) Sexually transmitted infections		Male	Female	TOTAL
STI 1	Number of clients treated for Sexually Transmitted infections			
COMPONENT 5:INTEGRATED AND COORDINATED PROGRAMME MANAGEMENT AT ALL LEVELS				
j) Research studies		Initiated	Completed	
RE 1	Number of operational research studies and surveys initiated and completed (i.e. internal review, mystery client survey, needs assessment surveys, evaluation of VCT/IEC messages, client survey etc)			
RE2	List Titles of research projects			
k) MALARIA		Below 5 years	Above 5 years	Total
MAL1	Number of malaria cases in-patient			
MAL2	Number of malaria cases out-patient			
MAL3	Number of reported deaths due to malaria			

Achievements in implementing HIV / AIDS, TB and Malaria activities	

Challenges faced in implementing HIV / AIDS, TB and Malaria activities	

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: _____

Designation: _____

Date: _____

WHERE SHOULD I SUBMIT THE FORM TO ONCE IT HAS BEEN COMPLETED

This form needs to be completed within 15 days of the end of the month, and should be approved by the supervisor of your Directorate/Division. Once this form has been completed, it should be submitted to:

Attention:

Response Monitoring & Evaluation Subdivision
Directorate of Special Programmes
Ministry of Health and Social Services
Private Bag 13198, Windhoek, Namibia
Tel: +264-61-2032288/9/92
Fax: +264-61-224155

FOR OFFICE USE

Received by and Date Received		
Verified by and Date:		
Captured by and Date:		
Filed by and date:		

Annexure B: Quarterly Report Format for other Public Sector Ministries/Agencies

1. Report Identification Details

Report date:		
Quarter reporting on:	From:	Year:
Name of Ministry/Agency:		
Directorate:		
Division/Subdivision:		
Postal Address:		
Name of M&E Focal Person:		
Report Compiled by:		
For more information / questions about the report, contact:	Name:	
	Tel number:	Fax:
	Email:	

2. Activities

COMPONENT 1: ENABLING ENVIRONMENT							
		Male	Female	TOTAL			
EAB1	Number of Ministries/Agencies that have a HIV/AIDS workplace policy						
COMPONENT 2: PREVENTION							
a) Life skills education (LSE) for HIV/AIDS		In-school		Out-of-school		TOTAL	
		Male	Female	Male	Female		
LSE1	Number of learners exposed to life skills education						
LSE2	Number of teachers trained in LSE for HIV/AIDS						
LSE3	Number of AIDS awareness clubs established						
	Number of schools with teachers who have been trained in life-skills-based education and taught it during the last curriculum year						
b) Condom distribution			Male condoms	Female condoms	TOTAL		
ABC1	Number of condoms distributed free to the general public						
ABC2	Number of persons trained in condom promotion						
c) Information, Education and Communication (IEC) materials		RADIO		TV		PRINTED	
		Number	Hours aired	Number	Hours aired	Number printed	Number distributed
IEC1	Number of new HIV/AIDS radio/ TV programmes produced and aired						
IEC2	Number HIV/AIDS brochures/ booklets/news letters/posters printed and distributed						
			Male	Female	TOTAL		

IEC3	Number of communicators trained to strengthen coordination and capacity building on IEC at the local level			
IEC4	Number of Ministries/Agencies with HIV/AIDS awareness services			
IEC5	Number of people reached through HIV/AIDS awareness outreach (theatre shows, presentations, etc)			
COMPONENT 3: EQUAL ACCESS TO TREATMENT, CARE AND SUPPORT SERVICES				
e) Increased availability & access to voluntary counseling and testing		Male	Female	TOTAL
VCT1	Number of clients counseled and tested for HIV			
VCT2	Number of VCT centres established			
VCT3	Number of people trained to provide VCT services (trained in counseling)			
f) Home based care and support				
CAR1	Number of persons trained to provide home-based care and support for chronically ill persons			
CAR2	Number of chronically ill persons receiving home based care (or enrolled in HBC and support projects)			
g) Antiretroviral treatment		Male	Female	TOTAL
ART1	Number of persons currently on ARV			
ART2	Percentage of caregivers and health workers who received post-exposure prophylaxis (PEP)			
h) Workplace Projects				TOTAL
WP1	Number of workplaces that have been provided support to develop workplace policies according to national code on HIV/AIDS in employment			
WP2	Number of Ministries/Agencies that have established a condom distribution system			
WP3	Number of workplace officials trained to develop and implement workplace policies			
i) Peer education		Male	Female	TOTAL
PE 1	Number of service providers trained to provide peer education			
PE 2	Number of people reached through peer education			
COMPONENT 4:IMPACT MITIGATION SERVICES				
j) Care and support (OVC)		Number Male	Number Female	Total
OVC1	Number of orphans and other vulnerable children receiving psychosocial, nutritional or material support			
OVC2	Number of persons trained in providing psychosocial, nutritional or material support to OVC (CBO/village committee members, community volunteers, family members, caregivers etc)			
OVC3	Number of NEW OVC's who enrolled for care and support			
COMPONENT 5:INTEGRATED AND COORDINATED PROGRAMME MANAGEMENT AT ALL LEVELS				
l) Ministries/Agencies				TOTAL
MUN1	Number of Ministries/Agencies with work place policies			
MUN2	Number of Ministries/Agencies with HIV/AIDS focal points			
MUN3	Number of Ministries/Agencies with HIV/AIDS committees			
MUN4	Number of Ministries/Agencies HIV/AIDS committees trained to design, manage and implement HIV/AIDS Projects			

m) Research studies		Initiated	Completed
RE 1	Number of operational research studies and surveys initiated and completed (i.e. internal review, mystery client survey, needs assessment surveys, evaluation of VCT/IEC messages, client survey etc)		

Achievements in implementing HIV / AIDS, TB and Malaria activities

Challenges faced in implementing HIV / AIDS, TB and Malaria activities this Quarter:

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: _____

Designation: _____

Date: _____

WHERE SHOULD I SUBMIT THE FORM TO ONCE IT HAS BEEN COMPLETED

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 Ministry of Health and Social Services
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 Fax: +264-61-224155

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Received by and Date Received		
Verified by and Date:		
Captured by and Date:		
Filed by and date:		

Annexure B: Quarterly Report Format for Civil Society and Private Sector

1. Report Identification Details

Report date:				
Quarter reporting on:	From:	To:	Year:	
Type of Organisation				
Name of Organisation:				
Postal Address:				
Name of M&E Focal Person:				
Report Compiled by:				
For more information / questions about the report, contact:	Name:			
	Tel number:		Fax:	
	Email:			

2. Activities

COMPONENT 1: ENABLING ENVIRONMENT							
		Male	Female	TOTAL			
EAB1	Number of PLWHA provided with advocacy and communication skills training						
EAB3	Number of large enterprises/companies/ministries that have a HIV/AIDS workplace policy						
COMPONENT 2: PREVENTION							
a) Life skills education (LSE) for HIV/AIDS		In-school		Out-of-school		TOTAL	
		Male	Female	Male	Female		
LSE1	Number of learners exposed to life skills education						
LSE2	Number of teachers trained in LSE for HIV/AIDS						
LSE3	Number of AIDS awareness clubs established						
	Number of schools with teachers who have been trained in life-skills-based education and taught it during the last curriculum year						
b) Condom distribution			Male condoms		Female condoms	TOTAL	
ABC1	Number of condoms distributed through social marketing						
ABC2	Number of condoms distributed free to the general public						
ABC3	Number of persons trained in condom promotion						
c) Information, Education and Communication (IEC) materials		RADIO		TV		PRINTED	
		Number	Hours aired	Number	Hours aired	Number printed	Number distributed
IEC1	Number of new HIV/AIDS radio/ TV programmes produced and aired						
IEC2	Number HIV/AIDS brochures/ booklets/news letters/posters printed and distributed						
			Male		Female	TOTAL	

IEC3	Number of communicators trained to strengthen coordination and capacity building on IEC at the local level			
IEC4	Number of Municipalities with HIV/AIDS awareness services			
IEC5	Number of people reached through HIV/AIDS awareness outreach (theatre shows, presentations, etc)			
COMPONENT 3: EQUAL ACCESS TO TREATMENT, CARE AND SUPPORT SERVICES				
d) Prevention of Mother to Child Transmission (PMTCT)				TOTAL
PMT1	Number HIV+ pregnant women receiving a complete course of antiretroviral prophylaxis			
PMT2	Number of health workers trained for PMTCT services			
PMT3	Number of service delivery points providing PMTCT+ services			
e) Increased availability & access to voluntary counseling and testing		Male	Female	TOTAL
VCT1	Number of clients counseled and tested for HIV (includes pregnant women)			
VCT2	Number of VCT centres established			
VCT3	Number of people trained to provide VCT services (trained in counseling)			
f) Home based care and support				
CAR1	Number of persons trained to provide home-based care and support for chronically ill persons (i.e., CBO/village committee members, caregivers, community members, volunteers, pastors, family members etc)			
CAR2	Number of chronically ill persons receiving home based care (or enrolled in HBC and support projects)			
CAR3	TOTAL Number of new home based kits distributed			
CAR4	TOTAL Number of old home based kits replenished			
CAR5	Number of PLWHA support groups established			
CAR6	TOTAL Number of persons enrolled at PLWHA group			
CAR7	TOTAL Number of PLWHA provided with skills training (Income generation, advocacy, human rights, national code for HIV/AIDS and employment, positive living, advocacy, psychosocial support, ARV, treatment literacy, buddy system, food security, etc)			
g) Antiretroviral treatment		Male	Female	TOTAL
ART1	Number of persons currently on ARV			
ART2	Number people starting ARV for the first time			
ART3	Number of PLWHA who adhere to ARV therapy			
ART4	Number of people trained to provide support to family members on ART (includes HBC caregivers, family members, counseling staff)			
ART5	Percentage of caregivers and health workers who received post-exposure prophylaxis (PEP)			
h) Workplace Projects				TOTAL
WP1	Number of workplaces that have been provided support to develop workplace policies according to national code on HIV/AIDS in employment			
WP2	Number of workplaces that have established a condom procurement and distribution system			
WP3	Number of workplace officials trained to develop and implement workplace policies			
i) Peer education		Male	Female	TOTAL
PE 1	Number of service providers trained to provide peer education			
PE 2	Number of people reached through peer education			

COMPONENT 4:IMPACT MITIGATION SERVICES				
j) Care and support (OVC)		Number Male	Number Female	Total
OVC1	Number of orphans and other vulnerable children receiving psychosocial, nutritional or material support			
OVC2	Number of persons trained in providing psychosocial, nutritional or material support to OVC (CBO/village committee members, community volunteers, family members, caregivers etc)			
OVC3	Number of NEW OVC's who enrolled for care and support			
COMPONENT 5:INTEGRATED AND COORDINATED PROGRAMME MANAGEMENT AT ALL LEVELS				
k) NGOs and networking			TOTAL	
N 1	Number of Network members benefiting from training activities conducted by NANASO			
N 2	Number of training workshops for NANASO network members conducted			
l) Municipalities			TOTAL	
MUN1	Number of municipalities with work place policies			
MUN2	Number of municipalities with HIV/AIDS focal points			
MUN3	Number of municipalities with HIV/AIDS committees			
MUN4	Number of municipal HIV/AIDS committees trained to design, manage and implement HIV/AIDS Projects			
m) Research studies		Initiated	Completed	
RE 1	Number of operational research studies and surveys initiated and completed (i.e. internal review, mystery client survey, needs assessment surveys, evaluation of VCT/IEC messages, client survey etc)			

Achievements in implementing HIV / AIDS, TB and Malaria activities	

Challenges faced in implementing HIV / AIDS, TB and Malaria activities this Quarter:	

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: _____

Designation: _____

Date: _____

WHERE SHOULD I SUBMIT THE FORM TO ONCE IT HAS BEEN COMPLETED

This form needs to be completed within 15 days of the end of the month, and should be approved by the supervisor of your Directorate/Division. Once this form has been completed, it should be submitted to:

Attention:

Response Monitoring & Evaluation Subdivision
Directorate of Special Programmes
Ministry of Health and Social Services
Private Bag 13198, Windhoek, Namibia
Tel: +264-61-2032288/9/92
Fax: +264-61-224155

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Captured by and Date:		
Filed by and date:		

Annexure D: Resource Tracking Format for Implementing Agencies

1. Report Identification Details

Report date:		
Month reporting on:	From:	to:
Name of Organisation:		
Postal Address of Organisation:		
Type of Organisation		
Report Compiled by:		
For more information / questions about the report, contact:	Name:	
	Tel number:	Fax:
	Email:	

1. Resources

		GRN	DEV. Partner	NGO, FBO, CBO	Other	Other
RES1	What were the sources of funding for your organization last year? Name of funding organization					
RES2	How much (N\$) did you budget for activities on HIV/AIDS for the last 12 months?	Enabling Environment	Prevention	Assess to Treatment, Care and Support Services	Impact Mitigation Services	Integrated and Coordinated Programme Management
RES3	How much was your actual expenditure (N\$) on HIV/AIDS during the last 12 months?	Enabling Environment	Prevention	Assess to Treatment, Care and Support Services	Impact Mitigation Services	Integrated and Coordinated Programme Management

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: _____

Designation: _____

Date: _____

WHERE SHOULD I SUBMIT THE FORM TO ONCE IT HAS BEEN COMPLETED

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Ministry of Health and Social Services
Private Bag 13198, Windhoek, Namibia
Tel: +264-61-2032288/9/92
Fax: +264-61-224155

FOR OFFICE USE

Received by and Date Received		
Verified by and Date:		
Captured by and Date:		
Filed by and date:		

Annexure E: Resource Tracking Report format for Development Partner

1. Report Identification Details

Report date:		
Month reporting on:	From:	to:
Name of Development Partner		
Type of Development Partner (NGO, Multilateral, Bilateral, etc):		
Postal Address of Organisation:		
Physical Address of Organisation:		
Report Compiled by:		
For more information / questions about the report, contact:	Name:	
	Tel number:	Fax:
	Email:	

2. Resources

IEC1	What were the sources of funding for your organization last year?	GRN	Multilateral	Bilateral	NGO	Other
	Name of funding organization					
IEC2	How much (N\$) did you budget for activities on HIV/AIDS for the last 12 months?	Enabling Environment	Prevention	Assess to Treatment, Care and Support Services	Impact Mitigation Services	Integrated and Coordinated Programme Management
IEC2	How much (N\$) was your actual expenditure on HIV/AIDS during the last 12 months?	Enabling Environment	Prevention	Assess to Treatment, Care and Support Services	Impact Mitigation Services	Integrated and Coordinated Programme Management

I verify that this information is complete and correct and that I have not misrepresented any information in this report.

Signed: _____

Designation: _____

Date: _____

WHERE SHOULD I SUBMIT THE FORM TO ONCE IT HAS BEEN COMPLETED

This form needs to be completed within 15 days of the end of the month, and should be approved by the supervisor of your Directorate/Division. Once this form has been completed, it should be submitted to:

Attention:

Response Monitoring & Evaluation Subdivision
Directorate of Special Programmes
Ministry of Health and Social Services
Private Bag 13198, Windhoek, Namibia
Tel: +264-61-2032288/9/92
Fax: +264-61-224155

FOR OFFICE USE

Received by and Date Received		
Verified by and Date:		
Captured by and Date:		
Filed by and date:		

Annexure F: Format for Quarterly M&E Report

1. Executive Summary

This should be a one or two page summary of the overall report, with a focus on key statistics and changes in statistics, as well as a description of key trends and how these influence the implementation of HIV interventions.

2. Summary of findings

FROM THE QUARTERLY REPORTS SUBMITTED, according to each of the components of MTP III:

- Component one: Enabling Environment
- Component two: Prevention
- Component three: Access to Treatment, Care and Support Services
- Component four: Impact Mitigation Services
- Component five: Integrated and Coordinated Programme Management

3. Conclusions and recommendations

This report should focus on presenting information in a format that is useful and applicable to the information needs of its readers. Thus, this section of the report should focus on key recommendations and suggested focus areas for the following quarter. This should be an objective assessment based on the results of the various indicators, and should not be a narrative report based on what the person writing the report feels is important.

The following headings are suggested:

- a) Overall conclusions and recommendations
- b) Conclusions and recommendations per MTP III Components:
 - Enabling Environment
 - Prevention
 - Access to Treatment, Care and Support Services
 - Impact Mitigation Services
 - Integrated and Coordinated Programme Management

4. Bibliography /References

This section of the report should list all of the data sources that have been consulted and used in developing this report. A checklist and recording sheet has been provided overleaf to allow for easy capture of data source references while the report is being compiled.

Annexure G: Format for National Annual M&E Report

1. Foreword

This should be a statement by a political leader, preferably the Chairperson of the NAC.

2. Executive Summary

This should be a two or three page summary of the overall report, with a focus on key statistics and changes in statistics, as well as a description of key trends and how these influence the implementation of HIV interventions.

3. National Indicator Update

Impact Indicators			
Ref No	Indicators	Data source	Disaggregated by
1	HIV prevalence among pregnant women	National HIV sentinel survey report	By age group and sentinel site
2	Percentage of adults and children with HIV still alive at 6, 12 and 24 months after initiation of antiretroviral therapy	HIS (ARV)	By age group
3	Percentage of infants born to HIV infected mothers who are infected	PMTCT Programme estimate	By age group
Outcome, Output and Input Indicators			
Component 1: Enabling Environment			
Ref No	Indicators	Data source	Disaggregated by
4	The amount of national funds spent by the government, civil society, private sector and development partners on HIV/AIDS annually	Resource Tracking form/UNAIDS Matrix	By sector
5	Percentage of large enterprises /companies (including line ministries) that have HIV/AIDS workplace policies and programmes	Workplace survey (AWPS)NABCOA	By company/enterprise
6	Percentage of population expressing accepting attitudes towards PLWHAs	DHS/AIDS	By age group and region
Component 2: Prevention			
Ref No	Indicators	Data source	Disaggregated by
7	Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and taught it during the last academic year	Annual Education Census (AEC)	By type of school
8	Percentage of people reporting the consistent use of a condom during sexual intercourse with a non-regular sexual partner	DHS/AIDS	By age group, urban/rural and region
9	Number and Percentage of health workers who receive post-exposure prophylaxis (PEP)	HIS (ARV), /HFS, URC	By region
10	Percentage of young people taught life-skills-based HIV/AIDS education in past 12 months	AEC/ UNICEF	By age group, out-of-school/in school and region

11	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	DHS/AIDS	By age group, urban/rural and region
12	Percentage of young women and men who have had sex before the age of 15	DHS/AIDS	By age group, urban/rural and region
13	Percentage of women and men who had sex with more than one partner in the last 12 month	DHS/AIDS	By age group, urban/rural and region
14	Percentage of employees in public/private sectors that have been reached by work place programmes in the past 12 months	Workplace survey NABCOA	By sector and region
15	Percentage of women and men who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	DHS/AIDS, OPM	By age group, urban/rural and region
16	Percentage of transfused blood units screened for HIV	NBTS	
17	Number of people completing the testing and counselling process (pre-test, counselled tested, & Post-test counselled)	HIS (VCT), SMA	By age group and region
18	Number of new clients treated sexually transmitted infection	HIS	By age group, region and type of STI

Component 3: Access to Treatment, Care and Support Services

Ref. No.	Indicators	Data source	Disaggregated by
19	Number of health personnel/others trained to deliver ART/PMTCT /VCT/Rapid testing/TB/HBC services according to national/international standard	Training Information Management System (TIMS)	By region and type: ART, PMTCT, VCT, Rapid testing, TB, HBC
20	Percentage of health facilities with drugs for ARV/OIs in stock and no stock outs in last 6 months	Health facility survey/ PMIS	By region/Facility and type of medicine: OI or ARV
21	Percentage of HIV-positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission	HIS (PMTCT), QPAMR	By age group and region
22	Percentage of TB patients tested for HIV	Electronic TB Register (ETR)	By age group and region
23	TB treatment success rate	Formula-based estimate	By age group and region
24	Percentage of women and men with advanced HIV infection receiving ART	HIS (ARV)	By age group and region
25	Number of vulnerable populations (sex workers, mobile population ect) who report always using a condom every time they had sex in the last month	Behavioural surveillance or DHS/ AIDS	By region and type of sex worker: brothel, based, freelance, licensed, illegal, etc
26	Number of vulnerable populations (sex workers, mobile populations) who have ever voluntarily requested an HIV test, received the test and received their result	Behavioural surveillance or DHS/ AIDS	By region and type of sex worker: brothel, based, freelance, licensed, illegal, etc

Component 4: Impact Mitigating Services			
Ref. No.	Indicators	Data source	Disaggregated by
27	Percentage of orphans and vulnerable children whose households receive free basic external support in caring for the child	DHS/AIDS	By age group, urban/rural and region
28	Ratio of current school attendance among orphans to that of non-orphans	DHS/AIDS, EMIS, Census	By age group and region
Component 5: Integrated and Co-ordinated Programme Management at all levels			
Ref. No.	Indicators	Data source	Disaggregated by
29	Percentage of national, regional and sectoral management structures with comprehensive HIV/AIDS plans which are financed annually	Regional profile of RACOC, CACOC, & DACOC	By management structure
30	Percentage of line ministries reaching 80% of criteria measuring mainstreaming (e.g. policy, annual plans, guidelines, budget, management committees with HIV/AIDS on agenda)	Sector reports, Workplace Survey	By Ministry

4. Narrative description of each of the components as per MTP III:

Component one: Enabling Environment

1. Capacity Development: Leadership
2. PLWHA Involvement
3. Policy and Law Reform
4. Interventions to reduce Stigma and Discrimination

Component two: Prevention

1. Capacity Development: Prevention
2. Target Vulnerable Populations
3. Target Young People
4. Target the General Population

Component three: Access to Treatment, Care and Support Services

1. Capacity Development: Treatment, Care and Support
2. Treatment and Care Services
 - Laboratory services for HIV/AIDS management
 - Drugs and supplies systems
 - PMTCT+ services
 - Management of opportunistic infections
 - Collaborative TB/HIV/AIDS services
 - Provision of HAART
 - Home-based care
 - Access to care for vulnerable populations

Component four: Impact Mitigation Services

1. Capacity Development: Local Response
2. Services for OVC & PLWHA
3. Addressing Poverty

Component five: Integrated and Coordinated Programme Management

1. Developing HIV/AIDS Management Capacity
2. Management and Coordination
3. Programme Monitoring and Evaluation
4. Surveillance and Operational Research

5. Research

As a minimum requirement, this section should indicate:

- Whether a National HIV/AIDS Research Strategy has been developed
- The progress made with regards to the development of the research database
- Bullet point list of new pioneering research that has been undertaken
- Brief analytical summary from the research database, as follows:

6. Status of National M&E system

Due to its prominence, it is recommended that this section of the report should focus on the quality of data sources and the functioning of the national M&E system itself. This section should take the form of an objectives assessment of the “health” of the M&E system, by means of the following headings:

- Reporting on M&E system indicators in National M&E plan
- Quality of data sources

DATA SOURCE	STATEMENT ABOUT QUALITY
1. Demographic and Health Survey	
2. Health facility survey (SAM/SPA)	
3. HIS Annual report	
4. Annual Education Census	
5. DSP records / RACOC Questionnaire	
6. National HIV/AIDS M&E Report	
7. National HIV/AIDS research database	
8. NCPI questionnaire	
9. Quarterly Programme Monitoring Report	
10. Sentinel surveillance report	
11. Workplace survey	
12. ETR	
13. Behavioural Surveillance (DHS/AIDS, BSS)	
14. NBTS	
15. Sector report: Quarterly/Annual	
16. Other research/surveillance reports	

- Status of data flow to and from DSP/NACOP stakeholders, identification of bottle necks and recommendations for improvement
- Status of DSP/NACOP database and website, and recommendations for improvement
- Comments on the quality and frequency of dissemination requests – particularly in light of the ad hoc information needs which might have been submitted to DSP/NACOP

7. Implementing Partners and Development Partners

This section should provide the following summative information about DSP/NACOP's implementing and development partners, in tabular format:

INFORMATION ABOUT M&E PARTNERS	
PARTNER NAME	M&E STATUS (M&E staff, unit, reporting in place, collecting / forwarding data, etc)
OPM	
MLGHRD	
MGECW	
NPC	
MOE	
NANASO	
NABCOA	
Lironga Eparu	

8. Conclusions and recommendations

This report should focus on presenting information in a format that is useful and applicable to the information needs of its readers. Thus, this section of the report should focus on key recommendations and suggested focus areas for the following year. This should be an objective assessment based on the results of the various indicators, and should not be a narrative report based on what the person writing the report feels is important.

The following headings are suggested:

- a) Overall conclusions and recommendations
- b) Conclusions and recommendations per MTP III Components:
 - Enabling Environment
 - Prevention
 - Access to Treatment, Care and Support Services
 - Impact Mitigation Services
 - Integrated and Coordinated Programme Management

9. M&E Work Plan

This section should provide feedback on what has been achieved in terms of the work plan, identify gaps and suggest improvements for the next work plan. This section should summarise key M&E activities for the following 12 months. This should include major surveys to be undertaken, as well as anticipated research to be published.

10. Bibliography/References

This section of the report should list all of the data sources that have been consulted and used in developing this report. A checklist and recording sheet has been provided overleaf to allow for easy capture of data source references while the report is being compiled.

Annexure H: Terms of Reference M&E Committee

MONITORING & EVALUATION (M&E) COMMITTEE

Terms of Reference

Background

HIV/AIDS is a multi-sectoral activity and therefore many stakeholders are involved in the national response. The Government and development partners are guided in this task by the provisions contained in the Third Medium Term Plan on HIV/AIDS (MTP III).

The MoHSS/DSP is tasked by the government to coordinate the monitoring and evaluation (M&E) of the national response to the HIV/AIDS epidemic. Together with all stakeholders it is responsible for the national M&E framework.

The MOHSS/DSP needs to issue on a quarterly and annual basis an M&E report on HIV/AIDS to all stakeholders at national, regional and lower levels. The Government also has reporting requirements to international and regional commitments as the UNGASS Declaration, to which Namibia is signatory.

As part of MTP3, NAMACOC and NAEC are tasked to monitor implementation of the plan, to regularly discuss progress and constraints, and to report to the National AIDS Committee (NAC).

The MTPII mid-term review conducted during February 2003 stated that the coordination of overall monitoring and evaluation mechanisms and activities required strengthening and that a standardized system of reporting is required.

Objectives of the M&E Committee

The main objectives are:

- To guide the development of a national M&E framework for HIV/AIDS
- To provide technical advice for the coordination of the national M&E system and to the RM&E Subdivision in the MOHSS Directorate of Special Programmes
- To verify the quarterly and annual reports.
- To share information and ensure alignment and harmonization of all M&E mechanisms, activities and capacity building in Namibia.
- To provide advice to quality assurance, data validation and interpretation, and analysis.
- To ensure adequate reporting and dissemination
- To advise the HIV/AIDS RM&E Subdivision on a key set of essential indicators required to monitor the national response;
- To assist in mobilizing support for M&E
- To monitor the development of a sustainable national M&E system

Membership

The coordination mechanism for overseeing the M&E in Namibia is the M&E committee. The M&E Committee is composed of M&E focal points and technical experts from:

Government:

- Ministry of Health & Social Services (DPHC: Div: Epidemiology, DPP & HRD: Subdivision: MI & Research, DSP: Subdivision: RM&E)
- Ministry of Basic Education, Sport & Culture (EMIS)
- National Planning Commission Secretariat: Central Bureau of Statistics
- Office of the Prime Minister

- MRLGHRD
- NANASO
- NABCOA.)
- NPC
- MoF

Other Stakeholders:

- University of Namibia (Population/Research and Multi-disciplinary Research Centre)
- Polytechnic of Namibia
- 2-3 Research Institutions identified

Development Partners:

- CDC, European Commission, GF, Family Health International/USAID, French Cooperation AIDS, UNICEF

Chair and Secretariat

- The Chairperson of the committee will be a representative from civil society/private sector/Development partner who is skilled in M&E or a person designated by the M&E committee for this purpose. The Deputy Chairperson will be a nominated representative of the MoHSS. A person may remain chairperson for 2 years, provided that the person is still a mandated representative of the relevant stakeholder he/she represented when he/she first joined. The chairperson and deputy chairperson will be rotated after 2 years of service.
- Secretariat functions: The RM&E subdivision will provide the secretariat functions together with the RM&E subdivision of the DSP.

Frequency of meetings

Meetings will occur on a monthly basis on predetermined dates to provide timely progress reporting of activities. Meetings may be called by the Chairperson as determined necessary or on an as-needed basis, according to the situation. The venue of the meeting will rotate as best suits the membership.

Review of Terms of Reference

The TORs will be reviewed annually and changes made as deemed necessary by the M&E TWG.

Annexure I: Terms of Reference Informatics Subcommittee

M&E Informatics Subcommittee Terms of Reference

The Monitoring, Evaluation Informatics subcommittee in Namibia is intended to advise on activities concerning Monitoring, Evaluation and Information Systems.

Mandate

The Informatics subcommittee will advise on the implementation of the national M&E system. Specifically this subcommittee will conduct the following activities to fulfill its mandate:

Monitoring and Evaluation

- Advise and provide technical guidance in terms of piloting of the national M&E system
- Advise on the operationalization of the activity monitoring report system
- Provide strategic input into the annual review process

Information Systems

- Provide a mechanism to evaluate the effectiveness of IS on a periodic basis
- Ensure that the annual data collection mechanism is supported, functioning and appropriate
- Advise the DSP on the maintenance of data, standalone software and the website
- Advise on ongoing support and training for the DSP and user agencies

Membership

The membership of this subcommittee will be comprised of appropriate personnel from the coordinating bodies of Government (MOHSS), International groups, NGOs, and CBOs. The group will be chaired by an officer appointed by the Director of DSP.

Meeting times

The group will meet on a quarterly basis. The venue of the meeting will rotate as best fits the membership. On a six-monthly basis the chair of the group will present its progress and key issues emerging to the Director of Special Programmes.

Review of Terms of Reference

This TOR will be reviewed annually and changes made as deemed necessary by the M&E Committee.

Annexure J: Terms of Reference HIV/AIDS / TB / Malaria Research Subcommittee

HIV/AIDS, TB and Malaria Research and Surveillance Subcommittee Terms of Reference

This Research and Surveillance sub-committee is intended to provide inputs and technical expertise concerning Research and Surveillance in the field of HIV/AIDS, TB and Malaria to the Research Management Committee (RMC) at the MOHSS.

Mandate

The working group will advise on all aspects relating to research and surveillance with regard to HIV/AIDS, TB and Malaria. Specifically this group will conduct the following activities to fulfill its mandate:

Research

- Advise and agree to the National HIV/AIDS, TB and Malaria research strategy
- Participate in appraisal of all HIV/AIDS, TB and Malaria projects submitted for approval to the MoHSS
- May recommend for approval/non approval of all HIV/AIDS, TB and Malaria related research projects submitted for approval to the RMC
- Link collaborating institutions on research to ensure quality results and reporting
- Ensure and support dissemination of all research findings

Surveillance

- Provide technical guidance on surveillance to be undertaken
- Co-ordinate all surveillance done by different agencies to prevent duplication of effort
- Link collaborating institutions on surveillance to ensure quality results and reporting
- Ensure and support dissemination of all surveillance findings

Membership

The membership of this sub-committee will be comprised of appropriate personnel from the HIV/AIDS, TB and Malaria coordinating bodies of the Government (MOHSS), International groups, NGOs, CBOs, and representatives from the research community in Namibia. The group will be chaired by an officer appointed by the Director of Special Programmes.

Meeting times

The group will meet on a quarterly basis. The venue of the meeting will rotate as best fits the membership. On a six-monthly basis the chair of the Research and Surveillance sub-committee will present its progress and key issues emerging to the Director of Special Programmes for information and appropriate action.

Review of Terms of Reference

This TOR will be reviewed annually and changes made as deemed necessary by the M&E Committee.

Annexure K: List of Sectoral Cluster, Lead Agencies and Key Actors as per MTP III

	Sector Cluster	Lead Agency	Other Key Actors Representatives to include among others:	M&E unit or Focal person in Lead agency
1	Public Services Co-ordination	OPM	Office of the President, public service unions, GIPF, PSC, Employers Federation	
2	Agriculture Water and Rural Development	MAWRD	Lands and Resettlement, Dir: Forestry MET; Community Development in MWACW, NNFU, NAU, NAFWU, AgriBank, NDC, NGOs e.g. RISE, CRIAA; NAMWATER, NAB, NDC	
3	Child Welfare	MWACW	OVC Standing Committee, MoHSS Dir: Social Services, NGOs: e.g. Namibia Red Cross Society, Catholic AIDS Action, CCN, ELCAP, SSC, Lironga Eparu, CAFO	
4	Defence	MoD	NDF	
5	Education and Culture	Joint HIV/AIDS Unit, MBESC / MHETEC	MHETEC, NIED, Adult Education: COSDECs, NAMCOL, NANTU, NANSO, TUCSIN, Sports Codes, Clubs, UNAM, Polytechnic, Voc. Training Colleges, Colleges of Education, NYC, NGOs e.g. Ombetja Yehinga, Total Child Project, Childline/ Lifeline	
6	Environment and Tourism	Directorate Tourism (MET)	MET, NWR, Namibia Tourism Board, FENATA, Namibian Association of CBNRM Support Organisations (NACSO), NACOBTA, NNF	
7	Finance, Treasury and Resources	NPC	MoF, Treasury, NPC, Office of the Auditor General, Banking & Insurance sectors, GIPF, NEPRU, IPPR	
8	Fisheries	MFMR	MFMR, fishing companies, unions	
9	Foreign Affairs	MFA	UN Agencies, Foreign Missions and Diplomatic Communities, Development Volunteers e.g. VSO, UNV	
10	Sex	MWACW	Line ministries, NANAWO, Girl Child Project, Sister Namibia, WAD, Khomas Women in Development, UNAM, WCPU, LAC	
11	Health and Social Services	MoHSS Directorate: Special Programmes	MoHSS, Lironga Eparu, Nurses Association, other medical agencies, NaSoMa, SMA, Church and private health services, AMBTS, NIP, NGOs delivering prevention, treatment, care & support, medical insurance companies, Medical and para-medical boards, traditional healers, TBA, health sector & HIV/AIDS training institutions, development partners	M&E unit with staff

12	Information and Media	MIB	NBC, Take Control Task Force, MISA, print media, radio stations, advertising agencies, MoHSS: IEC, MBESC, John Hopkins University, media training institutions, MWACW, MBESC, MHETEC	
13	Infrastructure	MWTC	NAMPOST, TELECOM, NAMWATER, Las, ALAN, TransNamib, RCC, Air Namibia, WBCG, RCC, Air Namibia	
14	Labour, Trade and Industry	MoL	MTI, NABCOA, unions, NCCI, Retail industry, Namibian Business Coalition, Retail industry, JCC, Hawkers Association, NEF, Labour Advisory Council,	
15	Lands, Resettlement and Rehabilitation	MLRR	MLRR, National Federation of People with Disabilities in Namibia; MBESC Directorate: Special Education, MoHSS: Rehab, MoHSS Directorate: Social Services, Ehafo	
16	Legal	MoJ	MoJ, Offices of Attorney General and Ombudsman, Law Society, LAC, Legal Dept in UNAM, Assoc. of Para-Legals, NAMFISA	
17	Legislative	Parliamentary Speakers	National Assembly, National Council, Cabinet	
18	Mining and Energy	MME	Chamber of Mines, NAMDEB, and Oil companies, unions, NAMCOR, Small Miners Federation. NAMPOWER, ECB	
19	Prisons and Correctional Services	MPCS	MPCS, ALU, Lironga Eparu, organisations supporting rehabilitation (CRIS, BRIDGE, PFB & others)	
20	Regional and local government and housing	MRLGH	ALAN, ARC, NELAO, AMICAALL , Regional Councils, Traditional Leaders, Land Boards, Directorate of Housing, City of Windhoek, National Housing Action Group (NHAG)	
21	Local Authorities		Coordinated by: ALAN and AMICAALL and NALAO to target Local Authorities throughout Namibia	
22	Youth	MHETEC	National Youth Council, MHETEC: YHDP, Ombetja Yehinga, NANSO, Girl Child Project; City of Windhoek Junior Councillors; NYS, Youth Net, YWCA, CCN Youth Desk, Catholic Youth League, ELCIN Youth Desk, Lironga Eparu ambassadors, NAPPA, KAYEC	
23	Faith-based Organisations	CCN	CAFO, CAA, ELCIN, ELCRIN, CHS, Church AIDS Network, HIV/AIDS Church Forum	
24	NGOs	NANASO	AIDS Service Organisations and other NGOs, NANGOF, Lironga Eparu. INTERNATIONAL NGO'S NEEDS TO CLARIFY	
25	Private Sector	NABCOA	Representatives of members of NABCOA, NCCI, Chamber of Mines, Okatumbatumba Hawkers Association, Namibia Shebeen Association, Professional associations, ALU, ACT	
26	Development partners		USG, UN Agencies	



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